

THE MEDICAL AND SURGICAL REPORTER.

No. 1545.]

PHILADELPHIA, OCTOBER 9, 1886.

[Vol. LV.—No. 15.]

ORIGINAL DEPARTMENT.

COMMUNICATIONS.

CRITICAL REMARKS ON FRACTURE OF THE OS FEMORIS.

BY EZRA MICHENER, M. D.,
Of Toughkenamon, Chester Co., Pa.

Apologetical.—While I highly esteem the urbanity and professional attainments of my good friend Prof. Ashhurst, I must also accept him as the authorized *exponent* of the present teachings and methods of my honored *alma mater*. And his expositions sometimes cause *regrets*, which I feel it to be my duty to express.

I well remember when, seventy years ago, it was considered a *Quiz Club* feat to lay down Prof. Physick's dressings for fracture of the thigh with neatness and accuracy ready for the patient, when the fracture had been reduced. And the inquiry comes up, What progress have we made in these *three-quarters of a century*? We naturally look to our *exponent* for the answer. Well, we have knocked the *Physick block* off Desault's *long splint*, and have laid the *foot-tie* aside. We have *renounced* the time-honored *sine qua non*, the *reduction* of the fracture and *restoration* of the shortened limb; and we have substituted the "*American Treatment*," the *pulley weight* of a *hod of bricks*, more or less, to do—WHAT? To restore the *length* and *service* of the limb, with an *acknowledgment* that it is not capable of doing so.

My Dear Doctor: I am aware that my earnest expressions in regard to this grave inquiry have been accepted as the effect of undue excitement, or as the flickerings of

expiring reason in an old man. No! my dear doctor! I am indeed an old man, having braved the storms of *ninety-two winters*; but THOSE were not the senile sentiments of *yesterday*. They were the warm and vivid inspirations of *seventy years* ago. And the observations and experience of a long life has not abated their *freshness* or *intensity*. I may have reached the *goal* of human effort, but not that of a *desire* to alleviate the sufferings of poor humanity; though the *appeal* may seem to come back from the *portals* of another world.

I shall speak of fracture of the *shaft* of the os femoris as a *typical* lesion; leaving the surgeon to modify his procedure to meet any *complication* that may occur.

It must be remembered that the treatment of fractures is *mechanical*, and success will very much depend on the *skill* with which it is applied. The best means may fail in the hands of a careless or *clumsy* operator. They necessarily involve suffering and inconvenience to the patients, and it is the *sacred duty* of the surgeon to alleviate the one and ward off the others to the extent of his power.

Reference may be made to MED. AND SURG. REPORTER:

1881, January 8, On Fracture of Os Femoris.—*Michener*.

1881, November 19, How Bones Break.—*Michener*.

1882, February 4, Clinic on Fractures.—*Ashhurst*.

1882, December 31, Review of Clinic.—*Michener*.

1883, January 20, Another Clinic on Fractures.—*Ashhurst*.

1884, March 15, The Fracture Apparatus.—*Michener*.

The *sequence* as well as the *scrip*, seems to have a significance in this connection.

The inquiry resolves itself into four problems:

1. How bones break.
2. How to diagnose.
3. How to reduce; and,
4. How to treat—fractures.

I. How Bones Break.

Fractures are said to be either transverse or oblique, the latter being much the most frequent. This is *literally* true. But a long experience, sustained by the *artificial* fracture of *hundreds* of the long bones of animals, assures me that the obliquity seldom exceeds *forty-five degrees*; often much less.

I have learned from the same sources that the cylindrical bones *generally*, if they do not *always*, break in a *dentated* or toothed form, capable of *interlocking* and holding the fragments in position. And also, that this interlocking may readily be effected at the angle of obliquity, above named, or even a higher one. I would therefore, as a *practical guide* rather than a *literal truth*, consider all fractures *transversal*, so long as the fragments will *abut*, and *interlock*, and *hold* themselves together, aided by the *tonicity* of the femoral muscles.

My note of November 20, 1881, was written at the suggestion of mutual friends, and presented the views noticed above, with the conclusions to which they seemed to lead.

The response: "November 24, 1881. No doubt most fractures are, at first, serrated, and this serration may for a time keep the fragments together. Yet, on the conversion of the bone into granulation tissue—which precedes union—those serrations sometimes disappear, and hence consecutive shortening is very common. I cannot recall more than a single instance in which I have succeeded in curing fractured thigh without shortening."*

This reply was not satisfactory.

A graduate of the University of Pennsylvania, with the honored impress of a *Physick* and a *Wistar*, who ventured to think and to act upon his own responsibilities, after having treated a series of those fractures, as they presented during a period of more than half a century, in accordance with *views* and *methods* in a measure peculiar to himself, and with a success believed to have been *unknown*, and after having given them to the public, asked the *Professor of Clinical Sur-*

gery, in his *alma mater*, to investigate them. The reply was courteous, but curt:

"I cannot recall more than a single instance in which I succeeded in curing a fracture of the thigh without shortening."

And in a clinic a few days later he enforced the same sentiment:

"In adults, a certain amount of shortening is, I believe, unavoidable."

Is this, then, the *ultimum thule*, beyond which inquiry must not—can not go? Our boasted *science* is hardly prepared to tolerate such a degree of *transcendentalism*, from whatever source it may emanate.

The professor, in his clinic, illustrates this softening by an *extraordinary* case. He says:

"I remember a case in the Pennsylvania Hospital who had made a *good recovery* from fracture of the thigh, and was allowed to go about at the end of six weeks. There was, at that time, one-fourth or *one-half* of an *inch* shortening. After two or three days there was found *two inches* of shortening. At this time the callus uniting the bone is soft, and the pressure from walking readily causes consecutive shortening." (The italics are mine.)

I say *extra-ordinary*—so soft, that an *inch* and a *half* of the thigh bone should be thus *squashed out*, like so much putty, and the man still able to walk on with such a condition of the limb!!! Is there not a mistake here?

As I had just reported more than a *decade* of typical cases, from infancy to old age, without *shortening*, or a *limper*, and that, too, without *mechanical extension*, I could only reconcile the conflicting results by referring them to the *antipodal* methods we had employed—the one treating the *man* without treating the *fracture*; the other treating the *fracture* without treating the *man*.

II. The Diagnosis.

I have little to offer, except it be a caution not to harass the sufferer with needless pain. It is enough for us to know that a fracture exists. An old physician had just dressed a fracture of a humerus for a young lady, when a former student came in. The dressings were *kindly* removed to allow him to diagnose the case anew, to the great annoyance and suffering of the patient. It was a long-remembered cruelty. Where there has not been displacement and shortening, a sharp, deep-seated pain from the slightest sudden motion will generally tell both the existence and the location of the lesion.

III. The Reduction.

Here we must *part hands*, as the clinic

*I understand this expression to mean an *appreciable shortening*, with a *limp*—not what a medical friend has called "an inappreciable shortening, without limping."

appears to entirely ignore the *reduction* of fractures; does not even name the procedure.

The bones are so many *stretchers*, to keep the muscles in a healthy tension, ready for immediate action. When the stretcher is broken, their innate tonicity causes them to *retract*. Hence the usual shortening in this lesion. And this increases and becomes more *inveterate* the longer it remains displaced.

The remarkable manner in which bones break seems to indicate a wise provision for their more easy restoration. It is strange that the profession should neglect to avail themselves of so valuable an assistant.

It has also been found that retracted muscles, or other tissues, while they strongly *resist* any sudden movement, will passively *yield* to slow and gentle *suasion* without causing pain.

Before proceeding to reduce the fracture it may be well to have the dressings ready for immediate use. If difficulty is apprehended, place a long band under the shoulders, bring the ends over the axillæ in front and fasten them to the bedstead, for *counter-extension*, and provide a trustworthy assistant for a pull—a long pull—and, may be, for a strong pull; for it must not be forgotten that in most cases a slow, cautious change can be effected almost without pain. The *tensile force* should be in an *inverse ratio* to the *complaints of the patient*; no matter how much time may be consumed. The most refractory muscles will eventually yield.

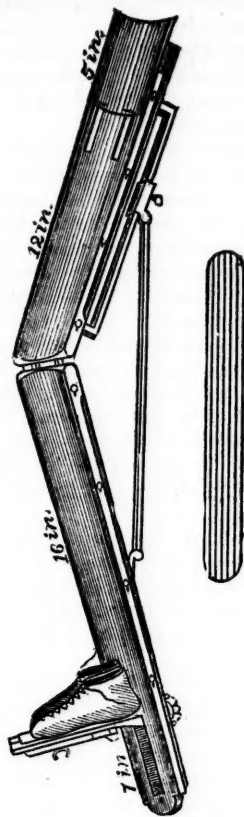
While the extension is being thus cautiously made, the surgeon must carefully manipulate the limb and watch the descent of the lower fragment until it gets clear of its fellow, when it will usually fall into position; and as the dentures drop together, they may not be easily displaced. The reduction may be tactile, or even audible, to the operator.

The tension may now be relaxed, as slowly as it had been made, to ascertain whether the bone will again serve as a *stretcher* for the limb. If it fails, further trial should be made. Finally, it may be necessary to dress the fracture while the full extension is kept up; and, perhaps, it should be continued for some time after. I have not seen such a case. When the fracture has been fairly adjusted, the femoral muscles are an excellent adjunct to hold them together.

IV. The Dressing, etc.

Sixty-five years ago (1820), I constructed an apparatus for fracture of the thigh in order to obviate defects in the methods then in use. It was partly on the plan of the *Ames-*

bury apparatus. Its use, for that long period, and in a variety of cases, from infancy to old



APPARATUS FOR FRACTURE OF THE OS FEMORIS.

age, has proved highly satisfactory. The figure explains itself.

The apparatus is seen to consist of a concave *bed splint* cut into two at the knee and united by *hinges*, with a sliding brace and binding tap screw to fix it at any desired angle. At the upper end is a broad brass *sliding plate*, with binding screws to adapt the length of the splint to the limb. Its edges are provided with *buttons* for the reception of four pairs of strong leather *straps* with buckles. Three *minor splints*, made of thin strips of wood, glued on muslin, answering to the length and thickness of the thigh, a strong *bandage of straps*, and *pads* for the splints, complete the essential dressings.

For the reception of the foot, and to adapt the apparatus to injuries of the leg, the lower section of the splint carries a *sliding standard* with a laced *shoe*, in which the foot may rest. It is also provided with side splints,

straps, etc. (not shown), for treatment of injuries below the knee.

In the case of children, I have always used an *improvised angular splint*, made on the occasion, by nailing two pieces of shingle on an angular block. The application and after-management were the same, and have been satisfactory.

The application is easy. If it was not done before reduction, remove the foot-gear, set the splint to a proper angle, say one hundred and twenty degrees, lay on the pad, and apply it accurately to the sound limb. The minor splints should also be trimmed to fit the thigh, from its top to the condyles and the patella, but never to rest upon them.

Now, lay down the bandage upon the pad and place the injured limb conformably on it. Apply the bandage tight; lay on the small splints with thin pads, and buckle the straps tightly over them. This completes the dressing proper of the fracture. The thigh was broken, and we have dressed the thigh.

Incidentally, the leg hangs over the lower plane. It needs a stocking. The foot-gear may be replaced and the foot be allowed to rest in the shoe, or on a cushion, to avoid the pain, too often produced, by pressure on the heel.

After a rest, and needed refreshments, revise every part of the appliances to know that there is *equable pressure*, and nothing to gall or produce irritation.

Remarks.—1. I studiously leave the hip and knee free to move that they may respond to any reflex motion of the patient instead of allowing it to fall on the fractured joint.
2. I have never used any form of *mechanical extension*, unless the angular splint be so considered.

3. I have not had either shortening or a limper.

Of the *softening and consecutive shortening* of fractured bones it may hardly become me to speak, for in the cases referred to it would seem that the *method pursued* had prevented either the *softening* or the resultant *shortening*. So far as my experience goes, I can hardly recognize it as *pertinent to good surgery*. It has presented to my mind, and I am willing to suggest whether it may not be caused, when it does occur, by the frequent disturbance of the fracture from insecure dressings—a form of *bone inflammation*. Two cases in which there could have been no mistakes go to sustain this view.

Case.—M. W., a child of seven summers, had her leg caught and dragged under a log, on the highway. The soft tissues of the up-

per anterior and inner tibial regions were entirely torn away, both bones broken, the leg doubled back upon the thigh, with the fragments all protruding more than an inch. After cutting away more than an inch of the upper tibia, which was denuded of its periosteum and left without any possible covering, the limb was placed on an angular splint, the nicely dentated ends of the fibula were held in the fingers and carefully interlocked, and supported by a light outside splint. Thus this young and broken *fibula* was made an efficient *stretcher*, and preserved the entire length of the limb during the long period of restoration of the *tibia*. There was no squashing out of *granulation tissue* here, for there was no shortening nor semblance of a limp.*

Case. Myself the sufferer. Some five years away, I fell with the right upper humerus across the sharp angle of a curb. The fracture click was unmistakable, and I immediately passed my hand over the *clavicle*, *acromion*, and *humerus*, without detecting a fracture. It soon became manifest in the latter, but was so near the joint that efficient dressings could not be applied. An axillary pad, with shoulder-strap to support and bind the arm to the side was applied, but was unsatisfactory, and permitted frequent disturbance of the fracture. I was not aware that the lesion had ever been much displaced. Union progressed slowly. But what was my surprise when putting on my coat to find the right sleeve apparently an inch longer than its fellow! *Ergo*, the injured arm was an inch shorter than it had hitherto been. I state the facts, others may apply them.

RESUMÉ.

What John and Jonas say contrariwise.

John.—I had laid a good while, and there was much shortening, and it required a good while to restore it; but it was done so cautiously as scarcely to give me any pain, and there was no shortening afterward. The bone made all the *extension* required.

Jonas.—My bone was never set. I, as I then thought, had happily escaped a painful operation, with the promise that the after-treatment would do all that.

My *American patriotism* had all been knocked out by the fall, but it returned amazingly, as I was assured that I should have the "American treatment." I didn't then know what that was.

*As this case was somewhat remarkable and is made to carry an unusual weight of testimony, I am free to state that she is now the wife of Goodwin Chalfant, near Unionville, in this county, and will verify this statement.

John.—My limb was placed on a close-fitting, curved, angular splint, with the knee gently flexed—a *Scullett's bandage*, and three *minor splints*, extending from the top of the thigh to the condyles—but not over them—when buckled tightly around the limb, constituted the *entire fracture dressing*. A stocking, and other comforts for the leg and foot were only incidental.

Jonas.—I was dressed with two splints—an outer and inner one. The first, “simply a long piece of board,” extending from the *axilla* to below the foot; the other from the *groin* below the foot. The outer splint rests upon the projecting point, of the *hip* and *external condyle*; the inner is held off by the *big end* of the thigh and *inner condyle*. Neither can give much *lateral support* to the fracture. To do this the interspaces were filled with *bags of bran*, which could hardly be expected to do better. I was finally *pinioned* down to this “long board” by five strong bands, and a *weight-extension* of one brick hung to the foot. (American!!)

John.—I laid *conformably* on a comfortable bed, with *bolster* and *pillows*, can be raised or even set up a little, and be laid off to refresh the bed. I suffered no pain, except from too long-continued pressure on the heel.

Jonas.—I laid *unconformably* on an uncomfortable bed. I soon learned the significance of the “American treatment,” and pronounced it a *tricuspid horror*, and withal a *failure*. *Its first cusp* is to be *pinioned down* on one's back to a long board from head to foot—a sort of *straight waistcoat*, worthy of the *Inquisition*. *Its second cusp* is the *weight extension* of bricks, increasing from day to day up to a *hod-full*, more or less, as the necessity of the case, or the whim of the doctor, may require. “Some surgeons use from twenty to thirty, and even forty pounds.”

The third cusp is the *counter-extension*, made by elevating the foot of the bed three notches higher than the head, with the promise of another notch for every additional brick. Nevertheless, “as far as my experience goes, shortening occurs after all fractures in adults.”

The two *forces*—*muscular contraction* and *gravitation*—one vital, the other mechanical, are *discordant*. They do not and cannot be made to *coördinate*.

John.—After six weeks the tight dressings were laid aside for lighter and looser ones. The *femoral muscles*—not the doctor—did not allow me to walk. They had been too tightly bound to resume their functions for some time. I used a crutch for a week or two.

Jonas.—At the end of six weeks my dressings were removed for lighter ones, but I was not permitted to walk on the injured limb.

John.—After eight weeks I was able to walk freely, without any *appreciable shortening*. But I was obliged to go out without the privilege of a *limper's diploma*, or a bill of *indictment* for bad surgery.

Jonas.—Eight weeks ago “I did not suppose much shortening, as extension had been made for forty-eight hours,” but on measurement it was still found to be one inch. But “this afternoon we shall probably add another brick, and in the course of a week, a third.” This was all done according to *Gunter*. But here I am with a limb still *one inch short*, and a *limper* for life. In return, I hold a *bona fide limper's diploma*, and a chance to *claim five thousand dollars* damage for bad surgery.

CONCLUSION.

My views may prove erroneous; they are certainly immature and not fully developed. The methods derived from them will doubtless admit of successful modifications. All I desire is, that they may be tried upon their own *intrinsic merits*, and be accepted or rejected, according to their *value*, regardless of the *bossism* of rival schools and the *assumed authority* of high positions.

Unhappily, *great men* make *great mistakes*. *Sanguiphobia* is not the only error taught in the schools, which, when innocently and confidently carried home by their thousands of medical students, tend largely to *people the tenement houses of the dead*.

ON SOME FACTS CONNECTED WITH THE ETIOLOGY OF TYPHOID FEVER.

BY R. W. HUTCHESON, M. D., M. R. C. S.,
ENG., ETC.,

Of Queen's County, N. Y.

Very much has been accomplished of late in extending our knowledge of the etiology and natural history of many diseases; so much so in fact that the science of medicine is making vast strides toward the time when it may be classed among the exact sciences. But there is much to be accomplished yet before that desirable era is reached; nevertheless the discoveries that have been made in our own times, and the skill and increased interest that have been lavished on very recent investigations, make us sanguine in our expectations that the near future is pregnant with results growing out of these investigations and discoveries; in other words, that

we are on the threshold of an important era in the history of the science of medicine. Would that we could say the same of the *art* of medicine! The fact is, the treatment of diseases at the present time is in a terribly muddled state, as any one who has been practicing medicine for twenty-five or thirty years must admit after reading some of the latest works on the practice of medicine. Not so, however, is the practice of surgery. The recent development of the germ theory has put surgery on a pinnacle of fame which few of us ever dreamed it would have attained in our day. And to the indefatigable exertions of professor Lister, of King's College, London, much of this success is no doubt due, for with his antiseptic dressings he has clearly demonstrated that much of our former ill success in surgery was due to the free access and rapid increase of germs in wounds; but by avoiding these and establishing proper drainage, wounds can now be rendered comparatively harmless, and healing by the first intention easily attained.

While these grand discoveries are being recorded they should stimulate each worker in the vast field of medicine and surgery to add his mite to the material that is wanted to make the sciences exact. City physicians and surgeons no doubt are doing Herculean work in investigating diseases; but they are not in a position to find out everything. There are many facts connected with medicine and surgery that the country doctor can discover, which do not come under the cognizance of the city practitioner. Facts, I say, are constantly occurring in the practice of country practitioners which if duly recorded would help to set at rest many of the uncertainties connected with the sciences of both medicine and surgery.

To illustrate my remarks let me take a disease, say typhoid fever. Now repeated observations have taught us how that disease is communicated from person to person when it has once started in a community. But whether typhoid fever originates *de novo*, and if so, how, are open questions; at least recent writers on medicine, ignoring the opinion of Murchison and other competent observers, tell us so. Now I ask, Could not the combined experience of the medical profession of the country solve that? Having had quite a number of cases of typhoid fever under my observation during the last twenty-five years, I have very naturally obtained some practical information from them, and a part of this relates to its etiology. I would, therefore, say that from my experience typhoid fever does originate *de novo*, and

that the cause is the ingestion of decomposed animal tissues under certain conditions, and among these tissues I should mention dead toads, rats, snakes, etc. Not only have I had frequent proofs of this in my own practice, but I have known it to occur in the practice of other physicians. The mere presence of dead toads in a well is not the only requisite to generate typhoid fever; they should remain in it long enough to become thoroughly decomposed, so as to impart a decided odor and taste to the water. In the instances that occurred in my practice, the wells were completely enclosed, so as to exclude the light, and only a very limited amount of stagnant air reached the water. It would indeed be a very interesting discovery if the bacillus typhosus could be demonstrated in these putrid walls; and, if they are the real exciting cause of the fever, they surely must be present in such instances in enormous quantities.

The following are some of the cases that I remember to have occurred in my practice where typhoid fever originated *de novo*.

1. A few years ago I was called to attend three children, living with their mother in a neighboring village. They had been complaining for several days, and were then ill with fever. There had been no cases of typhoid fever in the neighborhood for years, and the children had not been from their home for months previous to their illness. No one from any other part of the country had visited them. Every circumstance in fact incontestably proved that the disease could not have been communicated to them from any one. When a glass of water, drawn from the well from which they obtained their supply, was handed to me, I immediately detected an odor in it. "What is the matter with the water?" I inquired. "We don't know, doctor; the water has smelt like that for some time." "Don't drink another drop of it until the well has been cleaned," I replied. "The children are suffering from typhoid fever, and the cause of the fever you will no doubt find in the well." On the following day the top of the well was removed, and the *fons et origo* of the mischief soon came into view. Several dead toads, decomposed to a pulp, were found floating on the surface of the water. The fever in these cases ran the usual course, and the children under my care recovered. But an elder brother, living in the city, visited the house during their illness. He contracted the fever, and died at his lodgings away from home.

2. A year or so subsequent to this, I was summoned to attend another case of typhoid

fever. It was that of a farmer, aged fifty, residing with his wife and two children, who were at the time quite well. Before I arrived, these people had themselves detected that there was something wrong with the well-water, and had ceased to drink it. When the well was opened the surface of the water was found covered with the decomposed flesh of dead toads.

When informed that the illness was typhoid fever, the other members of the family were very much afraid of catching it. I answered them that the disease was not communicated from person to person like measles and scarlet fever, but was contracted in other ways—notably, through drinking water; that if they were careful in disinfecting and burying the excreta, and refrained from drinking their well-water, they would not take the disease. This allayed their fears for a time; but in about two weeks, down came the mother with the fever, and in a few days more the two children were also taken down with it. This, in their estimation, rather tended to upset my knowledge of the contagiousness of typhoid fever, and I had to set to work to discover how the disease originated in these latter cases. The family had ceased drinking the well-water, and had disinfected and buried all of the excreta. But there was another channel by which the fever might be communicated, of which they little dreamed, and that was through the milk. "Do you boil your milk before you use it?" I inquired. "No, we do not." "Where do you water your cows?" "From the well." "From the tainted well?" "Yes; we use the well-water for all other purposes, except drinking." This inquiry threw a flood of light on the subject; the cows drank the tainted water, the milk-pails and other utensils were washed with it, and those who drank the milk thus contaminated contracted the fever. This confirms a fact that was first shown by Ballard in 1871, and has been frequently mentioned of late by several writers, and is about the clearest case of the kind that has come under my own observation.

Soon after the fever had attacked the children, the friends employed a nurse to assist in taking care of them. She also, at first, was afraid of catching the disease. I assured her that if she would follow my instructions, and not eat or drink anything from the house where the sick were, she need have no fears of contracting it. She followed my advice and escaped.

3. In 1883 I remember attending another case of typhoid fever in which the disease no

doubt originated in the house where the patient resided. But in this instance the water was obtained from a driven well, which, as a rule, is less liable to contamination than the water from an open one. The house was built on a low plot of ground, and about four feet of pipe readily reached the water. There was a water-closet in the house, and the pipe leading from it ran under the kitchen, right by the pump, which had been driven but a few feet in the ground. Just where they met there was a leakage, and for months fecal matter had been allowed to escape and penetrate the soil, and thus reach the drinking water. The family resided in an isolated part of the country, and there was no other case of typhoid fever in the neighborhood at the time. The disease was of a severe type, but the patient finally made a good recovery. The drainage pipe was properly fixed, disinfectants were freely used, and no other case of the fever occurred in the family.

4. In the last part of August, 1885, a party of young folk, numbering some fifteen, started out to spend the day on the banks of a creek, near East Rockaway. They carried no water with them, but relied on procuring a supply from a sunken barrel near the creek that had been used for that purpose for a number of years. On this occasion it was noticed that the water smelled and tasted badly, so much so that some of the party refused to drink it. Exactly one week from the day of the picnic most of those who had drunk the water, some nine in number, were stricken down abruptly with typhoid fever. I regret very much that I did not have an opportunity of examining the barrel with its contents immediately after the picnic, as I am now left in doubt as to the cause of the decomposition in the water. Shortly after the outbreak of the fever, some person, fearing that others might drink the water, pulled up the barrel and destroyed the well. But from a number of reasons I can positively say that there was no possibility of the water being contaminated with the fecal matter of a patient suffering from typhoid fever, which is the recognized way of communicating the disease; and if the germs of the fever did not originate *de novo* in the well water, I ask the question, Where did they come from?

I might mention that the disease in these cases pursued the usual course of typhoid fever, some of the patients being ill for four or five weeks. There were several cases of relapse, and one of these died. The patients were treated differently. Quinine was ad-

ministered to some of them, both in small and large doses, but it had no effect in shortening the duration of the fever, thus clearly proving that the disease was not malaria.

TREATMENT OF PRURITUS PUDENDI.

BY E. S. M'KEE, M. D.,
Of Cincinnati.

In a paper read before the Cincinnati Academy of Medicine, September 20, 1886, on Pruritus Pudendi, the author discussed that interesting section, the treatment, as follows:

First, we should ascertain the cause of the disease to treat it intelligently. We should treat the constitutional diseases as the origin of the trouble. Next, we should treat the morbid phenomena, the pruritus. Remove the cause, and the pruritus will disappear of itself. The parts should be washed twice a day with castile soap and water. The diet should be vegetable, and regular action of the bowels maintained. As a general rule stimulants should be disallowed.

In this troublesome trouble, for we can hardly call it a disease, we need all the remedies we can find, hence I give all I know.

4	per cent. solution of	boracic acid.
3-10	"	carbolic acid.
2-5	"	argenti nitratis.
0.5	"	bichloride of mercury.
25-50	"	sulphurous acid.
6	"	sodii bborat.

Ointments of tar, boracic acid, camphor, or iodoform, mixtures of camphor and chloral, intusions of tobacco, 20 per cent. solution of chloroform in almond oil.

Treatment with the bichloride should be preceded by a removal of the mucus with warm water, and then dry with soft linen. Pass a sponge moistened with the solution rapidly over the affected part. This leaves a smarting, burning sensation, which is alleviated by a few minutes' washing with cold water. Subsequent applications become less and less painful.

M. Dubois recommends in the rebellious cases that the entire surface of the vulva be cauterized with a solid stick of the nitrate of silver. The great objection to this is that it is extremely painful, and the alleviation produced by it is almost always temporary.

Meigs recommends:

R. Borax,	3 ij.
Morph. sulph.,	gr. iiss.
Aque rose dest.,	3 viij.

M. S.—Apply three times a day to the affected part with a sponge or soft piece of linen. Take care to wash well the parts beforehand with soap

and warm water, and dry them well afterward. A compress dipped in the oil of sweet almonds and laid in the commissure of the vagina, is recommended.

When the trouble is general, temporary relief may be obtained by placing the woman in a prolonged soda bath, and subsequently rubbing the entire surface with vaseline.

Pruritus which has extended upon the distended abdominal walls is well treated with,

R. Lin. saponis comp.,	3 v.
Chloroformi,	3 j.
S.—Apply locally.	

If the itching comes from an ulcerated cervix, or more properly from the irritating discharge proceeding from it, apply nitrate of silver, and introduce a tampon of tannoglycerine.

Pruritus from breeding pediculi is well treated by mild mercurial ointments. Stavesacre answers well. A plasma formed of flour of sulphur and water, saline purgatives, as Pullna or Friedrichshall water. Vichy baths, or even bathing with cold or tepid water, constitute the best palliatives. Salines and colchicum may be indicated, also bromide of potassium. A weak solution of Goulard's lotion, or a lotion composed of

R. Liq. morphie hydrochlorate,	3 j.
Acid Hydrocyanic,	3 iss.
Aque,	3 vj.
M. S.—Use as a lotion.	

Pledgets soaked in the following and placed in the vagina have been found useful:

R. Acidi sulphuric,	
Sodii bicarbonate,	
Acidi sulphurici,	
Glycerini,	aa 3 ij.

M.—Insert at bed time and withdraw in the morning.

Iodoform may be dusted over the parts. The following has often given relief:

R. Chloroformi,	3 ij.
Ol. amygdal.,	3 ij.
M. S.—Apply externally.	

Morphia and chloral internally may be found necessary to obtain relief at night. Hildebrandt has found the tinct. cannabis indicæ, x.-xx. gtt., to be of even more benefit than these.

There is no end to remedies; the trouble is to get the right one.

R. Extract opii,	gr. v.
Plumbi acet.,	gr. x.
Acidi hydrocyanici, dil.,	3 j.
Aque, ad.,	3 j.

M. S.—Apply on lint to the vulva.

Or,

R. Liq. plumbi subacetat.,	3 j.
Acid hydrocyanici, dil.,	3 j.
Aque, ad.	0 j.

- R. *Acidi tannici*, 3ij.
Extracti belladonnæ, gr. x.
Butyr. cacao, 3v.
 M.—Div. in suppos. No. xx.
 S.—Insert one in the vagina night and morning.
- R. *Sodii biborat.*, 3ij.
Morph. sulph., gr. vj.
Aquæ rosæ, 3viij.
 M. S.—Apply to the vulva on lint.
- Trousseau recommends—
- R. *Potassii carbonat.*, 3ij.
Aquæ, 3iv.
 M. S.—Lotion.
- R. *Hydrargyri chloridi mite*, 3j.
Adipis, 3j.
 M. Ft. ungt. S.—Apply locally.

A solution of nitrate of silver (i-3j.) applied to the neck and cervical canal, so far as accessible, will often remove the pruritus even when due to pregnancy. If due to vesicular eruptions on the genitals this application should be made to the affected part.

Fox recommends the following:

- R. *Sodii hyposulphitis*, 3iv.
Glycerini, 3ij.
Aquæ dest., ad. 3vj.
 M. S.—Lotion.
- R. *Hydrargyri bichloridi*, gr. j.
Acidi hydrocyanici dil., 3j.
Emulsion of almonds, 3vj.
 R. *Acid hydrocyanici dil.*, 3v.
Infus. marshmallow, 3v.
 M. S.—Apply twice daily.
- R. *Sodii biborat.*, 3j.
Acid hydrocyanici dil., 3ij.
Aquæ rosæ, 3viij.
 M. S.—Use in the pruritus of old people.

- R. *Ammoniac acet.*, 3j.
Acid hydrocyanici dil., 3iss.
Infus. tobacco, 3viij.
 M. S.—Apply twice daily.

McCall Anderson recommends:

- R. *Potassii cyanidi*, gr. vj.
Pulv. cocci, gr. j.
Ungt. aquæ rosæ, 5j.
 M. S.—Use as ointment.

Guerneau de Mussey recommends the following:

- R. *Infus. marshmallow*, 1 litre.
Cherry laurel water, 50.00.
Sodii. sub borat., 10.00.

He then prescribes an ointment to be used night and morning as follows:

- R. *Glycerole of starch*, 20 00.
Pot. bromid.,
Bismuthi subnit., aa 1.00.
Hydrarg. chlor. mite., 0.40.
Ext. belladonnæ, 0.20.

De Savignac uses the above lotion, and then dusts the surface with the following powder:

- R. *Pulv. lycopodii*, 30.00.
Bismuthi subnitratiss, 19.00.
Bellad. rad., 2.00.

Dr. Martineau recommends an ointment of cocaine 1 in 10.

It is claimed by German writers that this pruritus is localized on a certain small area of the mucous membrane, and that by the removal of this part by the knife we remove the cause. This, I think, would have no effect on a case dependent upon the pregnant state, a discharge, or the condition of the urine.

EDITORIAL DEPARTMENT.

PERISCOPE.

Paralysis Depending upon Idea.

Dr. C. W. Suckling thus writes in the *Lancet*:

In the *Birmingham Medical Review* for June, 1885, I published an account of a boy who had suffered from paralysis of one leg for two years, and whom I was able to cure immediately after making the diagnosis of paralysis depending upon idea. Since then I have met with three other cases, two of which were men. In one case there was complete anæsthesia of the hand; in another hemi-analgesia with localized and severe headache. In the four cases I have now

seen, an accident occasioning slight injury was the exciting cause in each. All four cases were rapidly cured. Dr. Russell Reynolds, I believe, first described paralysis depending upon imagination. There is no malingering in these cases, but the patients are firmly convinced that they are suffering from paralysis. If the confidence of the patient be gained, an immediate recovery follows when he is told that he will be well immediately, the idea being got rid of. In making the diagnosis it is important to bear in mind the two classes of people in whom functional nervous disorders are met with—the neurotic and the hysterical—the features of which have been so graphically described by Dr. Clifford Allbutt in the *Gulstonian*

Lectures for 1884. It is the neurotic that is apt to be affected by these paralyzes depending upon idea, and it is these cases that are instantly cured when the diagnosis is made. The hysterical patient is cured with difficulty and frequently relapses; the neurotic does not relapse. The neurotic individual is vivacious, good-tempered, unselfish, intelligent, active, and industrious, anxious to be cured, and grateful for recovery. The hysterical individual is listless, apathetic, lazy, selfish, with characteristic expression, not usually anxious to get well, or thankful for recovery. The following is the fourth of these cases of paralysis depending upon idea that I have met with during the last twelve months.

Sarah F., a widow, aged forty-six, was sent to the Queen's Hospital, to be admitted under my care, by Dr. Middleton, of Harborne, on the 15th of March last, and was discharged well on March 28. She has led a very industrious life, having supported her five children by needle-work since her husband's death ten years ago. On October 9, 1885, she tumbled downstairs, falling down twenty-one steps on to her back. She was much hurt and "dazed" and very much frightened, thinking every bone in her body was broken. She walked about after the accident for a day or two, but suffered from pains in the back, down the legs, and round the body; these pains were intermittent, very severe, and lasted altogether three weeks. Two days after the accident she took to her bed, and a day or two later found that she was paralyzed in both her legs, and had lost all feeling in them. Since the accident she had suffered from constant headache and backache. Upon examining her, I found that she had a little power over the legs, but very little. Slight ankle clonus could be elicited on the left side. The plantar and abdominal reflexes were lost, but the knee-jerk was well-marked. There was complete analgesia and thermal anæsthesia in both legs up to the knees. She was unable to localize tactile sensations below the knees, the anæsthesia not being complete. When touched with a sharp-pointed instrument she said she felt as if she were being pushed. Muscular sense was unaffected. There was superficial tenderness over the lower dorsal spines, but no pain on firm pressure or on percussion, and no irregularity of the spine. The bladder and rectum were unaffected, and I was informed by Dr. Middleton that she never lost control over the bladder, nor had any sign of bed-sore during her illness. There was no œdema of the legs, no alteration of the temperature, and no change in

in the color or aspect of the skin or nails. In fact, there were absolutely no trophic changes whatever. The response of the muscles to faradization of their nerves was normal, but there was considerable electrical anæsthesia. In summing up the symptoms present, I of course observed their incongruity if we supposed the case to be one of myelitis, or, in fact, as due to any organic lesion. If the anæsthesia were due to actual lesion of the grey matter, how could the bladder and rectum escape? How was it that there was no sign of bed-sore, no œdema, or other atrophic change, such as muscular wasting? I diagnosed the case immediately as being purely functional, and, the woman being of the neurotic type, as paraplegia depending upon idea. I at once acted upon this diagnosis, and told the patient that I should give her the battery, which I said would at once remove the loss of sensation and enable her to move her legs as well as she ever did. She was delighted to hear this, and after a minute's faradization sensation was completely restored, and she had full command over her legs. I then told her that on my next visit I should expect to see her walking about the ward, for I was sure that she would be able to do so. I instructed Dr. Whittendale, my house-physician, to see that she got up after I left, and to apply the faradic current whenever she displayed any hesitancy. On my next visit, two days later, I found her up and able to walk and run about the ward perfectly well. She was quite delighted at her recovery, and had been most industrious with her needle since getting up. She expressed deep gratitude, and hoped to be able to repay our kindness. I may add that I saw my patient on the 14th of the present month (September), and she was remaining quite well.

How was the cure effected in this case? Undoubtedly, I think, it was by the mental state of faith or expectation, or both, on the patient's part. She fully believed what I told her, and thus I was able to remove the idea she had that she was paralyzed. The essential thing, then, in these cases, is to make a correct diagnosis, and then the patients can safely and with success be told that they will quickly recover. Now, had this been a hysterical woman, I should, in all probability, have failed to cure her, or, at any rate, the cure would have been more tedious. I recently had a woman under my care suffering from locomotor ataxy with hysterical anæsthesia. For two years I did all I could to cure the anæsthesia, and failed; but when she left the infirmary she applied leeches to

her legs and returned with the anæsthesia gone. Isolation, so useful in hysterical cases, is not needed in these.

In the same ward with my case of ideal paralysis there was a young woman suffering from hysterical neuralgia, and the contrast between the two patients was very marked. The hysterical woman was listless and apathetic, did not manifest any desire to be cured, and would scarcely allow that she was any better than when admitted. When told that she was well enough to go back to her duties as a teacher, she seemed disappointed, and said that she did not intend to begin work again for some months. The neurotic woman, on the contrary, wanted to leave the hospital immediately she could walk. The hysterical woman was observed to be always sitting opposite the neurotic woman, contemplating her, with her hands idly folded in her lap, watching the other busily working.

Such cases as these illustrate the enormous influence of the mind over the body. It is with these cases that the so-called faith-healers work pretended miracles. What an opportunity for a faith-healer my case would have afforded! Just as the mind has an enormous influence in causing disorders of sensation, of motion, and also of the organic functions, so, also, its influence can be used as a practical remedy in disease. As Dr. Wilks has well observed, "the practice of medicine is not only one of physic, but of psychology also."

Is Cirrhosis of the Liver Curable?

The *Medical News* says that this question has been discussed recently at La Société Médicale des Hôpitaux, according to the *Gazette Hebdomadaire*, Nos. 31 and 34, and answered affirmatively by several members, who quoted cases which seemed to bear out the view that the disease may be arrested or even cured. The diagnosis of cirrhosis is rarely reached until the onset of symptoms of obstructed portal circulation, although before this stage the condition may be reasonably suspected. The cases of cure are those in which the ascitic fluid has not re-accumulated after treatment, or, after a hæmatemesis, the symptoms have been relieved and the patient has had years of tolerable, or even good, health. Most physicians have met with such instances among their alcoholic patients.

In the discussion referred to, eight cases were reported by four or five members, and from the details we can reasonably infer that the ascites depended upon the cirrhosis. But

we must be careful not to confound the relief of a symptom with the cure of the disease. The post-mortem room affords examples of advanced cirrhosis in persons dying of intercurrent affections in whom there has never been any history of hepatic trouble, and on the other hand, the most extensive dropsy may exist with a very moderate grade of interstitial change. We must look beyond the liver for an explanation of these facts. In the first place, unquestionably, we must take into account the collateral circulation carried on by the diaphragmatic, œsophageal, and lumbar plexuses, the hemorrhoidal anastomoses, and the veins of the round ligament; if enormously enlarged, these may partially, or even fully, compensate for the narrowed portal channels, as in the rare instances of obliteration of the vena portæ. The degree to which this collateral circulation is established varies extremely in different cases, and is a very important factor in the duration of life in this disease. It will be found that the very instances in which advanced cirrhosis has been accidentally discovered post-mortem are those in which there are numerous supplementary blood-channels.

The two most striking symptoms of cirrhosis are ascites and hæmatemesis, in both of which the venous radicles of the portal vein are directly concerned. We are apt to consider them as immediate results of the heightened blood pressure, due to the narrowing and obliteration of the interlobular vessels; but Cohnheim's experiments indicate that this alone cannot induce either diapedesis or serous exudation. The condition of the vessels themselves must be taken into account, and in altered states of their walls we must seek an explanation of the sudden and profuse hæmatemesis, or the rapid dropsy. The abruptness with which one or other of these symptoms may supervene, as possibly the very first manifestation of the disease, points plainly to disturbances in the radicles of the portal veins, and not in the central hepatic branches, which in the indurated organ must be much less subject to variations in calibre.

Heretofore we have been in the dark as to the nature of these peripheral changes, but Dieulafoy has determined, in certain cases, the existence of a subacute peritonitis, and in four instances periphlebitis of the walls of the rootlets of the portal veins. These lesions have not been fully described, but their existence throws light on the origin of the dropsy and the hemorrhage, and they possibly furnish the additional factor which, as Cohnheim insists, is needed to permit

transudation of blood corpuscles or plasma under heightened blood pressure. The dropsy may be due to transitory and remediable causes, anæmia for example, and does not necessarily indicate that the contraction of the portal canals has reached a high grade. These are points which must be considered in discussing the curability of cirrhosis, and, as we remarked, the relief of a symptom may not mean the removal of the disease.

We probably have not any remedies at our command which are capable of curing a cirrhotic liver. The nature of the tissue change is such as almost to preclude the possibility of restoration, but in the early stage many practitioners place great reliance upon drugs, particularly the salts of gold, phosphate of sodium, chloride of ammonium, and, as recommended by Dujardin-Beaumetz, hippurate of lime. Unfortunately, the diagnosis in the cases in which these remedies have been reported to be successful is often a matter of doubt, and we very strongly suspect that when a case of cirrhosis presents features clearly enough marked for detection, the interstitial hepatitis is probably beyond arrest, as it is certainly past cure.

Fatal Case of Chorea Associated with Rheumatism and Cardiac Disease.

Dr. Martin Oxley thus writes in the *Lancet*:

The following interesting case has recently come under my notice:

Harriet B., aged ten years, had measles, scarlet fever, and whooping-cough before she was three years old. At the age of five she was in the Infirmary for Children suffering from rheumatism and chorea. She was admitted into the infirmary on the 21st of April of this year. Her mother stated that three weeks previously she began to suffer from rheumatic pains in her joints, and that one week before she was brought to the infirmary chorea set in. On admission, the patient complained of pain in the right knee and right wrist. She was also suffering from a well-marked attack of chorea, most marked on the right side. The choreic movements were more violent during the night, when awake, than in the daytime. The heart's apex beat in the fourth and fifth interspaces, internal to the nipple line. There was slight epigastric pulsation. A rough systolic thrill could be felt over the apex. There was a loud grating systolic murmur, heard most distinctly over the axilla. There was no œdema or albuminuria. A few days after admission

she had clonic twitching of the right side of the face, accompanied by incoördinated movements (described by the house-surgeon as being like an infant's convulsion). The patient improved considerably, and on May 25 she was sent to our convalescent home at Waterloo. She remained there for three weeks, and seemed to be improving in health and benefiting by the sea air. On her return (June 14) to the infirmary, it was noticed that there was much greater impulse over the cardiac region, and that the apex was now outside the nipple line. The chorea had disappeared, and she was allowed to be up and about the ward. A few days after her return she was noticed to have a slight rise of temperature at night (101°), and she was ordered back to bed. On July 2 the heart symptoms became much more marked, and her face and feet became œdematous. From this time she became rapidly worse, and died on the morning of July 11.

Post-mortem Examination.—There was slight œdema of the legs and eyelids. Heart very much enlarged, displacing the lungs, especially the left, and extending, partially covered by the thin edge of the lung, about half an inch to the right of the sternum and to the lower border of the second left rib. Pericardium: A patch of thick, firm, white adhesion, about the size of a sixpence, situated over the right ventricle near its apex, attached the two layers of pericardium; there were no other signs of pericarditis. On the surface of the aortic, mitral, and tricuspid valves, minute vegetations about the size of a pin's head were to be seen grouped in clusters. The aortic and mitral valves were both incompetent. The lungs were congested and œdematous all over; the left pleura was slightly adherent at the back. The liver was most typical nutmeg, and a large and apparently recent infarct was found on section.

Remarks.—This case, taken with others which have been reported, helps to strengthen the opinion held by many, that rheumatism and heart disease are responsible for chorea; and the fact that in chorea we frequently cannot find evidence of heart disease is no proof that there is no valvular disease. This was very well illustrated in a case which I brought before the members of the British Medical Association at their meeting in Liverpool in 1883. It just happened that many of my colleagues were examining cases in order to supply information to the Collective Investigation Committee, and a patient who was under my care at that time was frequently examined with the view of detecting

heart disease. No cardiac bruit could be detected, and there was no apparent hypertrophy; yet, notwithstanding, after death, which occurred unexpectedly during the chorea from exhaustion, vegetations about the size of pin's heads were found to fringe the aortic and mitral valves. In both these instances the vegetations were very small, and were very readily detached from the valves. In two other fatal cases of chorea which I have had under my care, the patients being of the ages of seven and eleven respectively, one had vegetations on the aortic and mitral valves, while the other had well-marked pericarditis and nodular rheumatism as described by Drs. Barlow and Warner.

Piperine in Intermittent Fever.

Dr. C. S. Taylor thus writes in the *Brit. Med. Jour.*:

As many cases of intermittent fever seem to resist the use of quinine, and all the other remedies in ordinary use, the following cases, which fell under my observation, will, I trust, exemplify piperine as an excellent addition to our knowledge of the treatment of this disease.

Case 1. M. J., aged 18, had suffered periodically, upwards of two years, with intermittent fever. It appeared that she had taken sulphate of quinine in great quantities, and in large doses, with the effect of only subduing the disease for a short time. She was sent abroad for a change of climate, and every other means had been used to cure the disease, without success.

Treatment.—She was directed to begin as soon as perspiration commenced, without regard to the heat of the skin, or quickness of the pulse, 3 grains of piperine every hour, until 18 grains had been taken; and on the following day, when intermission was complete, the same quantity every three hours. This has, in every case, succeeded in checking the paroxysm, and as soon as that is accomplished for some days, the following pills, taken in the morning, noon, and evening, will be found beneficial:

R. Pilulæ hydrarg.,	gr. j.
Piperinæ,	gr. ij.
Quinæ sulph.,	gr. iij.
Syrupi, q. s.	

Should the second paroxysm be escaped, the following pill should be taken every third hour:

R. Piperinæ,	gr. v.
Mucil. gum. acaciæ, q. s.	

It is now upwards of three years since the patient was treated, and she has continued free from the malady.

Case 2. Mrs. C., aged 34, had had several severe paroxysms of tertiary intermittent fever, but very irregular in its attacks. Infusion of cinchona, as well as sulphate of quinine, had been freely taken, but to no advantage. On April 15, while taking a cold bath, she was seized with ague. At 7 a. m. I found her shivering severely. I ordered warm drinks to be given frequently. At 12 o'clock, cold shivering continued, and the symptoms were alarming; the pulse was scarcely felt. The skin was cold, universally clammy, and unpleasant to the touch. The lips were of a slate-color. The countenance was contracted, the eyes sunken, and the patient evinced marks of great agitation and alarm.

Treatment.—Hot flannels were applied over the chest and abdomen; the legs and feet were rolled up in hot cloths, and stone vessels, filled with hot water, were constantly kept under her arms, and along the inside of the thighs and legs; and warm brandy toddy was given frequently in small quantities. At 4 p. m., finding the reaction could not be brought on, five grains of piperine were given. This was with great difficulty swallowed; it was, therefore, washed down with an ounce of brandy, in half a tumbler of champagne. Afterwards, full doses of the aromatic spirit of ammonia were ordered to be taken every third hour, and the champagne to be continued. At 6 p. m. reaction commenced, and, as the heat increased, the hot applications and stimulants were suspended. At 8 p. m. heat was general, and in proportion to the cold stage. On the following morning, the sweating stage commenced; and, as soon as it was general, five-grain pills of piperine were ordered to be taken every second hour, and continued for four days. On physical examination, the liver and spleen were found to be enlarged and hard, yet free from pain when pressed. The following pills were prescribed, and the patient was ordered to take one every two hours:

R. Piperinæ,	gr. xxxvj.
Pilul. hydrargyri,	gr. xij.
To be made into twelve pills.	

In case the bowels were not open, a wine-glassful of the following mixture was to be taken when required:

R. Sulph. magnesiæ,	℥ iss.
Sulph. quinise,	℥ ij.
Acidi sulph. dil.,	℥ ij.
Aquæ puræ ad.,	℥ xxx.

It is now three months since she first had an attack of the disease. Health perfectly restored.

There are a great many patients having an objection to taking quinine in consequence of its affecting the head; but the piperine, although a powerful stimulant, carminative, and febrifuge, does not in the least degree, from personal observations, affect the sensorium.

Chancre of the Gum.

Dr. D. N. Kinsman thus writes in the *Cleveland Medical Gazette*:

The peculiar mode of infection in the following seems to justify its publication. While there is, of course, an element of doubt, such as must exist in all such cases, I feel sure its origin is such as I shall detail.

B. consulted me June 24 concerning a swelling of the cervical and sub-maxillary glands on the right side. They were large, hard, painless, and without the adhesions to the surrounding tissues usual in the ordinary cases of adenitis of their duration.

In seeking for a cause for their development I found an ulcer surrounding the right middle incisor, in the upper jaw. This ulcer had been under treatment by a dentist for several days, and by him was supposed to be due to an accumulation of "tartar," which had extended beneath the gum and caused the ulceration. It had been treated with iodine locally.

I told him the glandular swellings were due to the ulcer, and when it healed the swelling would disappear. He returned to the dentist for treatment for a few days. I saw him again July 1. There was no change in the aspect of the case, except the glandular swelling was increased, and the glands of the other side of the neck and those in the occipital region were also involved.

I found he had fever and headache, for which I gave quinine. July 3 he was worse and sent for me to see him at home. At this visit the case became clear, for the papular syphilide upon his face, chest, and arms left no possible doubt. He subsequently had nocturnal pains in the head and shins, and pharyngitis and patches upon the tongue. Under specific treatment he did well, and in five weeks the apparent manifestations had disappeared. Three years ago this man was treated for supposed syphilis. This diagnosis seems to have rested upon the occurrence of a sore upon the penis and a consecutive suppurating bubo. He had none of the secondary accidents of syphilis.

For some time the origin of this chancre was a mystery. Finally, I learned that B. was having sexual relations with a young

woman who was living at home, and that they had continued for more than a year. In the early part of May, or last of April, this young woman, who till then had been free from all sores, had a fissure on her lip, which was cauterized with a crayon of nitrate of silver. This fissure took on the appearance of a broad-based sore, so the young man says, and for some time refused to heal. Finally, the glands in her neck enlarged. She had an eruption, and, upon consulting a physician, the case was diagnosed syphilis, and accordingly treated, when her symptoms subsided.

B. supposed that he had been poisoned when kissing her while her lip was sore, and I am led to believe, from all I can learn, this woman was contaminated by the crayon of silver, which may have been soiled by contact with a chancre on some one else. Such modes of infection are common enough. This case, as well as others, teaches us we cannot be too careful to protect others from contamination by soiled instruments which have been used about syphilitics.

Circumcision Under Cocaine—Improved Operation.

Dr. E. R. Palmer, Professor of Physiology in the University of Louisville, writes to the *Med. Record* that, desiring to perform circumcision under cocaine, he determined to use Corning's method of sequestration.

"The patient, a young man, twenty years old, with a complete congenital phimosis, was seated in a chair, and the penis was seized by my assistant and drawn upon firmly. A Martin bandage, seven-eighths of an inch wide and a yard and a half long, was next applied, the first turn being made behind the scrotum to prevent slipping, and the bandage being then wound tightly back and forth from the symphysis pubis to the corona and back again. An ordinary hypodermatic syringe was next filled with a six per cent. solution of cocaine, and the needle, directed toward the extremity of the penis, was passed at four different points through the skin over the glans, a fourth of the contents of the syringe being discharged each time into the subcutaneous tissue. No attempt was made to introduce the drug from the mucous surface. In about three minutes I began adjusting a Rogers clamp, occupying as many more minutes in getting it placed to suit me and screwed down. The prepuce was removed with one stroke of a pair of long curved scissors, and the clamp removed. The dorsal artery was found not

bleeding; the frænum was not cut. The mucous membrane was split up, and some eighteen sutures leisurely introduced. The bandage was now removed, and, contrary to expectation, no hemorrhage ensued. Less than a drachm of blood was lost during the entire operation. The wound was dressed loosely with absorbent cotton wet with equal parts of listerine and water. Not a twinge of pain was felt after the last needle puncture had been made. The young man, of nervous temperament, was at first quite pale, but later assisted in the stitching, and as he washed his hands after the operation remarked that his penis still felt dead. The wound healed in forty-eight hours by first intention.

"The advantages of the bandage are several: It wholly controls bleeding, it localizes the action of the cocaine, and it increases the facility with which the penis can be handled during the operation. The reverse direction for application, that is, from behind forward, will be found the best, because the easiest, and fully effectual."

Dr. Palmer adds that he performed the operation a second time in the same manner, with equally good results as regards anesthesia. But the continuous suture was used, and although perfect coaptation was accomplished, some trouble was experienced later from swelling and from syphilitic induration of the parts. It was attempted to remove the suture, but this was found impossible, and the writer thinks it would have been better had interrupted sutures been employed. The case is now doing quite well, however, and the result will be good.

Note on a Rare Dislocation of the Elbow-Joint.

Dr. C. George Battiscombe thus writes in the *Lancet*:

On April 9th I was called to see a gentleman who had met with an accident while hunting. I found him lying in a field, and was told that his horse, after jumping a fence with a long drop, had fallen over backwards upon his right arm and leg. He complained of great pain in the elbow-joint on the slightest movement. It was very much altered in shape, and evidently severely injured. I secured the arm in a sling, and had him removed to the Cottage Hospital (Chiselhurst, Sidcup, and Cray Valley), which was close by.

On his arrival at the hospital I examined the arm, and found it in the following condition: The forearm was fixed at rather

more than a right angle to the arm; all power of natural movement of the elbow-joint was lost; and any attempt at forcible movement caused great pain. The hand was partially pronated, but on turning it pronation and supination could be readily performed. The elbow-joint appeared too wide from within outwards and from before backwards; it presented two prominences below, an inner and outer, and one above the latter, which projected backwards and was continuous with the forearm. The inner angle of the joint was too high, so that the arm appeared to be shortened. There being no amount of swelling, the following points could be clearly made out. The ulna and olecranon were missing from their natural position in relation to the humerus, the two condyles of which could be distinctly felt with the notch between them. The ulna and olecranon were resting fully half an inch above the external condyle of the humerus, the elbow projecting about an inch beyond the latter. The radius could be felt above, with its head resting against the outer border of the humerus. It was not separated from the ulna, and rotated readily on pronating and supinating the hand.

I put the patient under chloroform, and carefully examined for any fracture. I could find none whatever, and concluded that it was a case of complete dislocation outwards of both bones of the forearm. I then proceeded to reduce the dislocation. Grasping the forearm with one hand, and the elbow with the fingers of the other, I pulled it steadily downwards, endeavoring to get the olecranon over the external condyle. It took some minutes to do this, and required a good deal of force. Then, holding the olecranon below the condyle with the left hand, I seized the forearm lower down and used it as a lever, and while forcibly extending the forearm I rotated it outwards. On continuing the extension, the olecranon suddenly slipped into its natural position. The joint immediately answered to all its proper movements, but when left alone tended slightly to return. I fixed it at a right angle on a posterior angular splint.

When I called in the evening the patient was free from pain, and complained only of a feeling of numbness in the arm and hand of the injured side. The next morning, when I arrived at the hospital, he had gone home; but I ascertained that, beyond the numbness and a little swelling, he was very comfortable. A week afterwards he was doing well, could move the joint pretty freely, and was free from pain.

Complete lateral dislocation of both the bones of the forearm is, I believe, extremely rare. I have seen no description of it, though it is mentioned in several surgical works.

Antipyrin as an Analgesic in Headache.

Dr. John Blake White, Physician to Charity Hospital, New York, sends the following to the *Medical Record*:

"The high road to truth is the knowledge of facts, and well is it for searchers after truth when facts can be ascertained and carefully recorded.

"Symptoms are the alphabet, cases the language, of disease, and that physician subverts his profession who carefully records his experience.

"During the past two years I have abundantly tested the therapeutic value of the drug known as antipyrin in various forms of headache. The prompt relief obtained through its use compels me to accord to it a high rank among our medical resources. I have already called attention (*Medical News*, July 10, 1886,) to the potent antipyretic power possessed by this remedy in the management of various forms of fever, and have observed that after its administration the urgent symptom of headache, so uniformly present in these cases, was soon controlled.

"Antipyrin undoubtedly possesses bradycrotic properties in a high degree, as the pulse is notably softened and moderated in frequency soon after a proper dose of it has been taken. It produces some somatic change favorable to a reduction of the pulse in cases of fever, and so exerts a calming influence upon the vaso-motor system. The capillaries, through its agency, doubtless dilate, and local congestions are dissipated, as the relieved patient usually sinks into a refreshing repose soon after its exhibition. In the course of large experience with antipyrin I have found that, when administered in masterful doses, it not only promptly relieves the symptom of headache whenever present, whether resulting from disordered digestion, disturbance of the menstrual functions, loss of sleep, undue mental effort, or even that associated with dreaded uremia, but also possesses reliable prophylactic virtues against recurrent attacks of cranial neuralgia. So confident am I of the power of this remedy to disappoint neuralgic headache when imminent, that I have instructed many patients, who are liable to such visitations, to keep in readiness and take a dose of antipyrin as soon as they have premonition of its recur-

rence, and all so far testify in favor of its efficacy.

"The value of this remedy in the above respect has not only been tested in my hospital and private practice, but I also record the fact it has proved successful in the hands of professional friends, upon whom I had urged its employment for the relief of neuralgic affections of the head and face. I have been singularly impressed with the promptness of relief which often followed the administration of even a single dose of fifteen grains of the antipyrin. The grateful relief from headache usually ensues within half an hour after the drug is taken. A sense of drowsiness ordinarily supervenes, followed by a brief but sufficient slumber, and the patient awakens quite relieved of this distressing symptom. I have never yet seen the sleep-disposing properties of antipyrin alluded to by any other observer, although this effect seldom fails to ensue when a full dose such as I have named has been taken."

Ergot in Labor.

Dr. J. W. Macfarlane thus writes in the *Med. Times*:

We notice in a number of journals of late that ergot is given a prominent place in the management of labor, some recommending it in the second stage, whilst others believe it to be indispensable to the proper management of the third. This journal of September 4 contains an article by Dr. Reichard endorsing it unequivocally in the third stage.

That ergot is a remedial agent of great virtue there is no question; that it should be given in every case of labor seems not only irrational, but harmful.

Labor is a physiological process, and where nature is capable of performing its functions properly it seems meddlesome, to say the least, for the *accoucheur* to give a dose of ergot when the after-birth is expelled and the uterus firmly contracted, under the impression that it will ward off septic trouble and what not.

It is questionable whether ergot should be given in the second stage of labor. One is probably debating whether to apply the forceps or not, and, to get out of the dilemma, or to be doing something, gives ergot. When I was a resident physician, hour-glass contractions of the uterus and retained placenta were not uncommon things under the use of ergot, and the consequent manipulation to remove the after-birth (which several times necessitated the introduction of the

hand) left the patients nervous, exhausted, and liable to hemorrhage.

When there is any difficulty in the third stage of labor, we use the Credé and Cazeaux methods combined. If there is a disposition for the uterus to relax after the removal of the after-birth, the patient is placed upon her back, and the fundus of the uterus is grasped with one hand, whilst two fingers of the other hand are introduced into the vagina. Under these circumstances the neck of the uterus is generally filled with a large clot. A little manipulation with the external hand and fingers within the vagina brings on firm contractions of the uterus, and the clots are forced out into the palmar surface of the hand, and thence into the bed.

In cases of post-partum hemorrhage we empty the cavity of the uterus that we may secure perfect contraction. Why not invite a relaxed uterus to contraction in the same manner, when we have the means so ready at our command?

We have never seen the above-named procedure fail to procure firm contraction, though we have, in certain cases where the patients were feeble, followed it up with ergot, to guard against any possible danger.

Lying-in women generally get along without a bad symptom. Why make them sick by the use of ergot?

The "Strangers' Cold."

Mr. R. Augustine Chudleigh writes to the *Brit. Med. Jour.*:

"Under its Maori name of murri-murri, I have been for eighteen years much interested in the St. Kilda cold, and everything connected with it. When Boswell and Johnson visited the Hebrides, in 1773, the disorder was evidently an article of popular belief, though the medical man himself had as little respect for the mysterious cold as for the Rev. Kenneth McAulay, who vouched for its existence. In *Tour to the Hebrides*, Boswell says, at page 126, that, from his conversation, Dr. Johnson was persuaded that McAulay was not capable of writing the book on St. Kilda which goes by his name. And, at page 343, he waxes merry over the idea of people catching cold merely because strangers came; for, says he, if one stranger gave them one cold, two would give them two colds, and a ship-load would kill them. He further adds that the evidence was not adequate to the improbability of the thing; and not till a physician should go to St. Kilda and report the fact would he believe in its existence. It appears from your journal

that several physicians have visited St. Kilda since 1773, but they have not quite settled the question of *enatan na gall* either way. May I, therefore, cite the case of the island of Wharekauri, one of the Chatham group, about 480 miles east of New Zealand, nearly at the antipodes of St. Kilda, where, under the name of murri-murri, an identical disorder, with a similar alleged origin, is now frequent. In its main features, murri-murri is indistinguishable from a severe influenza cold. Its invasion may occupy four hours; the patient remains 'intensely miserable' for about four days, when the disorder gradually dies away. No period of incubation precedes, and no permanent ill-effects are observed to follow. One attack does not preclude the recurrence, and European residents, as well as Maori and Murioti natives, are liable to the disorder. In order to be infected, a person need not know that a ship has come; indeed, the mere appearance of murri-murri is proof to the inhabitants—even at distant parts of the island, which is thirty miles long—that a ship is in port, inasmuch that, on no other evidence, people have actually ridden off to Waitangi to fetch their letters. There is a hill whence one can see across the island into Waitangi Bay; and people are wont to climb this hill, and scan the bay for a ship, on no other evidence than the occurrence of murri-murri. It is very curious that the name of that hill is Mount Dieffenbach (see Mr. Dixon's letter, *Brit. Med. Jour.*, page 286, 'Darwin quotes Dieffenbach, etc.'). and that the ship that would have been descried thence would almost certainly have been the *St. Kilda*, which, for many years, did the trade of the islands. There may have been connection between St. Kilda and Wharekauri."

Effects of Syphilis in Pregnancy.

Dr. Louis Hirigoyen, who has published a series of articles in the *Journal de Médecine de Bordeaux* embodying the results of observations on the effect of syphilis upon the course of pregnancy, states that in the Bordeaux Maternity Charity, in which five-sixths of the cases are those of unmarried women, the syphilitic are 5 per cent. of the whole number. The author's observations go to confirm Fournier's dictum that "a syphilitic woman becoming pregnant is more likely to abort than a pregnant woman who becomes syphilitic." For example: Of eight women who had been syphilitic for more than a year, five aborted, one bore a child which died on the eighth day, and two bore living but puny

children. Of nine women who contracted syphilis within the first two months, six aborted at six months, and three at seven months, all of macerated children. Of three women who contracted syphilis during the third month of pregnancy, one miscarried at seven months of a macerated child, and two of a similar child at eight and eight months and a half respectively. So that in all the twelve cases where syphilis was contracted before the commencement of the fourth month miscarriage of a dead fetus resulted, even in some cases in which anti-syphilitic treatment was diligently pursued, the only apparent effect produced being the retardation of the period of miscarriage. Syphilis occurring after the commencement of the fourth month proved less fatal, for of four cases which took place from the fourth to the sixth month, one brought forth a healthy child at eight months; the second, who was treated medicinally, went her full time, and was delivered of a healthy child; while the other two women were confined at seven and eight months respectively of puny children, which died shortly after birth. Where the infection was delayed till after the beginning of the seventh month, it proved still less fatal to the children. Thus, of seven cases of this kind four terminated in the delivery of apparently healthy children, and one more might have been born alive but for maternal dystocia. The bodies of the macerated children, as well as those which died after birth, were examined, and no definite syphilitic appearances could be discovered in the osseous or other parts. Of course, treatment was adopted where the woman was seen early enough, and in all cases stringent isolation and antiseptic precautions were enforced, with the result of the avoidance of all serious accidents.

A Study of the Cause and Treatment of Pelvic Hæmatoceles.

Before the Chicago Gynecological Society Dr. H. T. Byford cited the case of a non-suppurating, retro-uterine hæmatocele of six months' standing, which he evacuated *per vaginam* March 18, 1886, and then treated with antiseptic irrigations. She was up and about the house in eleven days. As the odor and discharge were still causing discomfort, the doctor, influenced by the advice of Apostoli and Doléris, curetted the cavity. He found no more blood or debris, but started up a mild attack of local peritonitis, which delayed instead of hastening the cure. The patient left the hospital in a little less than

a month after the cessation of all discharge. A small lump of induration extending from the abscess opening to the right sacro-uterine ligament was all that was left of the tumor.

The following résumé of interesting points in the case is given:

1. The length of time from the occurrence of the hæmatocele to the time of operation, about six months.
2. The method of opening the cavity, viz., by first tearing the vaginal wall, and afterwards the sac wall.
3. The absence of fluid in the tumor.
4. The breaking up of the mass with the finger without an attempt at thorough curetting or removal of the entire contents.
5. The complete disintegration and discharge of all bloody substance in thirteen days.
6. The absence of high temperature—102° F. having never been reached.
7. The small amount of anodyne required—one dose (except the two doses to relieve the irritation from subsequent unnecessary curetting).
8. The toleration of strong antiseptic solutions. It was necessary to weaken them on account of their effect upon the vagina.
9. The absence of the usual amount of odor in such decomposing masses.
10. The large quantity of food taken throughout.
11. The absence of any kind of sickness from the beginning until the cavity was curetted.
12. The curetting of the cavity on the thirteenth day delayed her recovery, producing the only serious symptoms that were noticed.
13. Notwithstanding a set-back of ten days, caused by the curetting, she was well enough to go home inside of a month and dispense with treatment.
14. The attack came on after a miscarriage.

Emotional Icterus and Lichen.

So many cases of emotional icterus are on record that it is scarcely worth the while to enter into a statistical discussion to show the existence of such an affection. Dr. Negel, of Jassy, Roumania, reports, in *Progrès Médical*, of August 21, a "case of emotional icterus accompanied by a general eruption of lichen," which is sufficiently rare to give in detail. The patient was twenty-three years old, of robust constitution, with a tendency to obesity, and for some years subject to acne of the face and back, and there was

slight submaxillary engorgement. There was no hereditary taint in the patient.

In February, 1885, there was a herpetic eruption on his prepuce, which he himself treated with cauterizations of nitrate of silver, as a result of which there was an enormous ulcer and balanoposthitis. He then consulted a physician, who ordered emollient dressings, but the ulcer grew larger. To make a long story short, the physician finally told him that his penis would gangrene; but the patient showed so much alarm that Dr. Negel was consulted. When he arrived some time later, he found that the patient's urine was brown, and left a deposit in the *pot de chambre*; the fecal matters were colorless, and there was slight constipation. This state lasted for two days, when the patient noticed that his saliva was bitter, and there was slight fever. There was now intense icterus, accompanied by an eruption of lichen, situated principally on the thorax (back and sides), abdomen, and face, the limbs and scrotum. It was of the simple variety, and presented a few vesicles here and there. The urine contained a great deal of bile pigment. An emeto-cathartic was given, and then saline purgatives, lemonade, bicarbonate of soda, and antiseptic dressings were applied to the ulcerated and swollen prepuce.

After ten days of treatment the ulceration and balanitis were almost cured, but the lichen persisted. The icterus had greatly diminished. After about three weeks the patient was practically well, but there was still some jaundice and lichen.

Diaphragmatic Hernia.

Il Bullettino della Reale Accademia Medica di Roma (May, 1886, p. 245) contains a description by Dr. Ferraresi of a diaphragmatic hernia revealed in the necropsy of a young man who had died with symptoms of intestinal strangulation. On surface inspection of the well-nourished body, it was noted that the abdomen was only slightly swollen; the left half of the thorax was broader and more prominent than the right, and the left intercostal spaces dilated. Percussion revealed an area of absolute dullness over the whole left chest, excepting the subclavicular triangle, which yielded tympanic resonance. On opening the abdominal cavity, the coils of small intestine, slightly reddened, presented small patches of fine basal injection. Carefully opening the thorax, the left pleural cavity was found filled with a bloody liquid, on giving exit to which the lung, compressed

and driven upwards, became visible, the heart being displaced to the right. Besides liquid already referred to, the pleuritic cavity contained numerous coils of intestine enormously distended, of dull red color; the serous membrane was opaque, rough, and studded with numerous hemorrhagic spots. The stomach was displaced to the right, with the great curvature turned towards the abdominal wall. Holding aside the stomach and the small intestines, still retained in the abdomen, it was observed that the splenic angle of the colon and a good part of the jejunum passed into the pleural cavity through a hole in the left inferior half of the diaphragm at a point corresponding to the normal position of the heart's apex. The descending colon was much contracted. With great difficulty, and after repeated punctures, it became possible to reduce the coil of colon, a piece of omentum; and the displaced small intestine. The hole in the diaphragm was oval, rather more than an inch in diameter, surrounded by a strong, thick, fibrous ring. The gastro-colic omentum which followed the displaced coil was shortened, and adherent posteriorly to the margin of the fibrous ring.

Bacteriotherapy in Pulmonary Tuberculosis.

The plan of treating pulmonary phthisis by the inhalation of spray containing bacterium termo, the organism of putrefaction, has received a severe handling from some of the fellow-countrymen of its advocate, Prof. Cantani, of Naples. At a meeting of the Medico-Chirurgical Society of Pavia, held on March 20, Prof. Giuseppe Sormani read a paper on the subject. After criticising the principle from a theoretical point of view, he recorded three cases where the plan was carefully and rigorously carried out, and even for a longer time than had been recommended by Prof. Cantani. The results in these three cases were altogether negative. The conclusion was that bacteriotherapy was not a remedy, either rational or practical, against tuberculosis. Prof. Sormani thought, however, that the inhalation of the spray of fresh good meat-broth might act as a palliative against distressing cough, difficult expectoration, dyspnoea, and other symptoms. He advised, therefore, recourse to this means in suitable cases; without, however, for a moment thinking of first putting in the broth a bacterium which was certainly useless and might be noxious. Prof. Riva, in speaking on Sormani's paper, criticised the scientific basis of Cantani's method. The basis of the method was that there was a struggle for ex-

istence between the bacterium termo and the bacillus tuberculosis. The bacterium termo, however, subsisted only on dead substances; so that wherever one sent it, it would only take its nourishment from the excretions, or from mortified tissues, and would not attack the proliferating tissues of tubercle. The only result would consequently be the decomposition of the excretions, which, being in the neighborhood of a large absorbent surface, might be carried into the circulation, and might act hurtfully on the organism. In answer to questions touching Sormani's three cases, it was stated that in one case only was there a rise of temperature of some tenths of a degree. Whether the urea increased or not was not known.

Parenchymatous Injections of Quinine in Ague Cake.

Professor F. Fazio relates in the *Rivista Clinica e Terapeutica* for July, 1886, the case of a woman, thirty years of age, who had suffered from malarial fever, and who had also marked hypertrophy of the spleen. The tumor extended from behind the margin of the ribs to a line drawn on a level with the anterior superior spine of the ilium. It was determined to attempt a reduction in the size of the spleen by means of parenchymatous injections of quinine. The instrument used was the ordinary hypodermic syringe provided with a longer and thicker needle than usual. The bisulphate of quinine was employed, and thirty-two injections of each $4\frac{1}{2}$ grains were made, care being taken to make the successive punctures at some distance from each other. The result of treatment was a reduction of over one inch in the length of the tumor. The injections were not followed by pain or by any other unpleasant symptoms. The experiment was interrupted by the departure of the patient from the hospital, but Dr. Fazio believed that the results obtained were sufficiently encouraging to warrant further trials of the method.

Scarlatina.

The *Birmingham Medical Review* contains a contribution to the pathological anatomy and histology of scarlatina by Dr. Crooke. It is remarkable that the mammilated appearance of the pyloric region of the stomach was very marked in a case that terminated fatally in twenty-six hours. Microscopical examination showed that this appearance was due to inflammatory hyper-

plasia of the adenoid tissue, which is normally present in the gastric mucous membrane of children and young adults, as Dr. Herbert Watney has demonstrated. At some places the hyperplasia is seen to be so considerable as to extend up to the surface of the mucous membrane, displacing in its extension the gastric tubules. Whilst able to corroborate the accuracy of the observations of Dr. S. Fenwick as to the presence of interstitial gastritis in scarlatina, Dr. Crooke does not regard the interstitial change as evidence of a past morbid process. He believes that simple catarrhal gastritis occurs in a more or less marked degree in most cases of scarlatina, fatal during the febrile stage; but that in cases characterized by the exceptional severity of the gastric disturbance, where the interstitial changes are so pronounced as in three cases examined by him, the condition is usually, if not invariably, associated with a similar acute interstitial and follicular inflammation of the mucous membrane of the intestine, and is therefore to be regarded as part of an acute inflammatory attack, of which the chief stress falls on the adenoid tissue of the stomach and intestines.

Induction of Premature Labor.

Dr. T. Gaillard Thomas says: The method of inducing premature labor which I now invariably adopt is a very simple, and is at the same time a perfectly efficient one. The patient is placed across the bed, with the buttocks resting near the edge, and under is arranged a large piece of rubber or oil-cloth in such a way as to drain into a tub on the floor. In this tub we put one or two gallons of water at a temperature of ninety-eight degrees Fahrenheit. The operator stands between the thighs of the patient, whose knees should be properly supported, and employing a syringe with a long nozzle, which is carried up as far into the cervical canal as it will go, he keeps a stream directly against the membranes. In the course of ten minutes the os will be the size of a silver half dollar, and when dilation to this extent has been accomplished, he is to insert a gum catheter between the membranes and the uterine walls. The patient is then put to bed, rhythmical uterine contractions soon follow, and the labor is completed in a few hours.

—Free dispensaries are almost unknown in France, there being but three in Paris, according to the correspondent of the *Provincial Medical Journal*.

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PHARYNGEAL CATARRH AND PEPSIN.

Dr. J. Fisher, of Berlin, had a patient suffering with chronic pharyngeal catarrh (*Berl. kl. Woch.* 49-86). Various local and internal remedies were tried in vain, until finally, the patient complaining of some transient gastric disturbance, caused by too luxurious a meal, the Doctor advised him to take five grains of Jensen's pepsin, which by the way is also recognized in Germany as the best pepsin in the market, immediately after each meal. The patient, who from the frequent medication had become averse to medicine, took the pepsin pure, $\frac{1}{2}$ grain of aromatic powder being added to 5 grains of Jensen's pepsin simply to preserve the latter in its dry state. The effect was remarkable. Not only the stomach improved, but after three days' use the pharyngeal catarrh also showed decided amelioration. Dr. F. then administered the pepsin in still larger doses, ten grains each, and two weeks later the catarrh had disappeared. The same remedy was afterwards tried in four more cases and with the same result, but other pepsin preparations failed.

There is one symptom, that seems always to yield readily to Jensen's pepsin, viz., the peculiar dryness, of which patients suffering from chronic pharyngeal catarrh are so apt to complain. The remedy ought to be taken in its pure state, only a moderate dose of aromatic powder being added to keep it dry, and it should be allowed slowly to dissolve in the mouth.

There is a complaint intimately connected with the catarrh in question, viz., circular ulceration of the posterior nares. Patients suffering from this trouble usually have to hawk a great deal every morning, sometimes also in daytime, to their own disgust and that of others, until finally they expectorate a round piece of hard muco-pus, with the scab from the ulcer. The hawking is often so great that it leads to vomiting, and the symptom itself is a very annoying one. In a similar accidental manner as Dr. F., Dr. Hugo Engel discovered that Jensen's pepsin, if regularly used in divided doses (10 to 15 grains 3 to 4 times daily), especially if combined with muriate of ammonia (20 grains 3 to 4 times per diem), and with powdered extract of liquorice (same dose as the muriate), to improve the taste, is almost a specific in the complaint spoken of. Only one must be careful to obtain the genuine Jensen's pepsin, there being many similar but worthless preparations in the market, and they are substituted but too often for the genuine article on account of their great cheapness. The

tablets of Jensen's pepsin are well adapted for the purpose indicated, and may be taken separately from the sal ammoniac. In that case the aromatic powder may be omitted.

THE MICROBE IN HEREDITARY SYPHILIS.

How difficult it often is to discover the germ in infectious diseases, and how easily mistakes are made even by experts in bacteriology, the following incident taken from the *Deutsche Med. Zeit.*, No. 52, 1886, will prove:

Drs. Kassowitz and Hochsinger, in Vienna, had found in the tissues (skin of pemphigus, bones, liver, pancreas, lungs, and thymus) of five grave cases of hereditary syphilis a micro-organism which seemed specially characteristic by its size, form, and arrangement. The same microbe could never be discovered in the tissues of children not luetic. The micro-organism seemed to depend upon the lesions caused by hereditary syphilis. Its main seat is the vascular system and of the tissue nearest to the blood-vessels. The fact of these organisms being met with on the surface of the red blood-corpuscles, and only in organs to which the atmosphere has admittance, appeared to demonstrate the necessity of the presence of oxygen for the development of the microbe.

To determine whether it was really a special germ of its own kind the usual investigations showed a peculiar action of coloring matter, a characteristic chainlike arrangement of whole colonies and the relation already mentioned to blood-vessels. Rosenbach's pyogenic streptococcus exists only in the lymph-spaces of the skin, while that of erysipelas is found only with pus.

The specific germ of lues in its altered form of hereditary syphilis seemed to have been found; but the observers sent specimens of the newly-discovered microbe to Dr. Kolisko, of the Pathological Institute in Vienna. He succeeded by pure cultures and inoculations in proving the identity of the streptococcus described with the pyogenic one above mentioned, and he thus explained the reason why the microbe of K. and H. has been found only in grave cases of hereditary, and why not in acquired lues, viz.: because in the former alone pyogenic processes develop, the consequence of the presence of the pyogenic streptococcus.

POISONING BY OPIUM.

Dr. C. Plaster, in Munich (*Münch. Med. Wochschr.*, May 6, 1886), reports the case of a vigorous man, who, with suicidal intent,

had swallowed about one drachm of a preparation of opium destined for smokers, a kind of dried aqueous opium extract. When he was brought to the hospital he was in the stage of severe depression, which manifests itself by utter cessation of all reflex excitability and of all voluntary motion. Emetics, dry friction, cold affusions, artificial respiration, and the injection into the œsophagus of strong black coffee, were without any result. But two injections of $\frac{3}{16}$ gr. of sulphate of atropia, each produced transient dilatation of the pupils and some improvement in breathing. Death, however, ensued in a few hours later.

The post-mortem examination showed hyperæmia of the brain and its membranes in an extraordinarily high degree, and this fact causes the author to ask the question, whether under such circumstances as those narrated, venesection was not the only means promising any success. We believe the suggestion a good one, for though it is admitted that venesection would relieve the fullness of the blood vessels but for a short time, the latter is all that is wanted in so grave a case of opium poisoning. If we only succeeded in re-establishing active circulation within the cranium for the shortest space of time possible, our other remedies would have time to eliminate the poison. Besides, blood-letting not only diminishes for a moment the amount of blood in the congested vessels, but by diluting the blood it diminishes the vis a tergo, lessens the existing hyperæmia more permanently, and stimulates absorption and increased activity of the skin. There is, however, another question to be inquired into: Do the large doses of atropia, if not successful in restoring the patient to life, themselves give rise to, or at least favor the congestion of the brain?

A PECULIAR EFFECT OF MASSAGE.

That massage has to credit many of its successes to the fact that it increases and stimulates the peripheral circulation is known, but Dr. Pogosher, of Moskau (*Sjetopissy Chirurg. Obchestwa u. Moskur*, 7, 86, Russ.), has recently discovered another important effect of manipulation.

He connected a sphygmograph with the radial artery of an arm, which was being manipulated by a masseur. He noticed that while the massage was practiced from the periphery towards the centre the arterial pressure was at first increased, later diminished. But if the movement take the opposite direction, viz., from the centre towards

the periphery, the opposite effect sets in, the arterial pressure first suffering a diminution, later an increase.

We learn from this discovery that by massage we may alter ad libitum the quantity of blood in the vessels, and it will be now only necessary to find out whether the same result may be obtained in disease as in health—a rather important point, considering that the experiments were made on a healthy person, and that most individuals for whom massage is mainly indicated generally suffer from some malady connected with morbid changes of circulation.

TUBERCLE-BACILLI IN SUPRA-RENAL CAPSULES.

The frequent occurrence of disease of the supra-renal capsules in Addison's disease is not only generally recognized, but no authenticated case has yet been recorded, where this malady had happened without a lesion. Various morbid changes of these parts have been reported, but the discovery of Rauschenbach—the presence of tubercle-bacilli in the supra-renal capsules in Addison's disease—seems to bring us a step further.

Rauschenbach's observations are published in the *Revista de Ciencias Méd.*, May 5, 1886. We see from his article, that only one drawback exists, which greatly imperils the usefulness of his discovery. The supra-renal capsules were not alone diseased; other parts of the bodies, examined by him, also were the seat of a tubercular process. We cannot assume, therefore, that the lesion of the supra-renal capsules in Addison's disease is always produced by the tubercle-bacillus; but we may say, that various morbid processes, when attacking the capsules, may give rise to the peculiar bronzing of the skin so characteristic of the malady in question. That phthisical patients often present a bronzing of their skin, sometimes greatly simulating Addison's disease, and not seldom really suffering from it besides their main tubercular lesion, has long been known.

NOTES AND COMMENTS.

Gumma in the Pons.

A case of a gumma in the pons, of extraordinary interest on account of a descending degeneration in the medulla oblongata and medulla spinalis, has been published by Dr. Pasquale Ferrare (*Estratta dalla Rivista Internat. di Medic. e Chirurgia*, 10, 1886).

The new growth had commenced remarkably early—about fifteen months after the

primary affection. It started from the right lower portion of the pons, penetrated through the whole thickness of the latter to its left side, and had destroyed the pyramidal fibres, the ascending root of the trigeminus, and the oculo-motorius on the right side, while the facial fibres were compressed on both sides, and had partially been obliterated. During life the following symptoms indicated the existence of the lesion.

The right bulbus had deviated toward the inside and upwards, diplopia existed, further left-sided hemiplegia and hemianæsthesia, paralysis of both sides of the face and of the muscles of the pharynx, in consequence of which latter occurrence the voice had a nasal sound, the speech had become indistinct, and spontaneous deglutition was impossible, the act, when performed, being completely an involuntary one.

The secondary degeneration in the cord concerned the posterior lateral columns and the inner portion of the anterior; at the same time single fibres of the main bundle of the anterior column and of the lateral were affected on the left side, as also the gray substance of the left anterior cornu. Besides, there was noted as the consequence of a compression of the right pedunculus cerebelli a degeneration in the left rectiform body, in the left olive, and in the whole motor field of the left half of the medulla oblongata. Some peculiar anomalies in the course of some pyramidal fibres are also mentioned by the author, and in this fact we probably find the explanation of the somewhat erratic course of the descending degeneration.

Cases of larger single new growths due to lues are rather rare, and the question remains: Was the degeneration due to syphilitic dyscrasia, or did it have its origin from the tumor?—i. e., was it caused by compression and thus by want of blood supply?

The Presence of Iron in Diabetic Patients.

In many cases a great quantity of iron is met with in the liver of persons suffering from diabetes mellitus, and some observers have gone so far as to look upon this augmented quantity as an evidence of diabetes. To determine the point whether iron is indeed always present in an increased degree in the liver and the spleen of such individuals, Dr. Zaleski has made a series of investigations (*Virch. Arch.*, Bd. 104, H. 1). and arrived at the following conclusions:

When present, the iron may show itself in two ways: either it penetrates all the tissues of the organism, or it forms special deposits,

where it gradually accumulates. In the first case it becomes an integral part of the cells; it does so most commonly in the liver and spleen. To discover it careful chemical and microscopic examination is necessary, while the microscope suffices in cases of special deposits.

Brownish, rusty-colored deposits of pigment, a very frequent morbid phenomenon, do not give the reaction of Fe in every case of diabetes, neither is siderosis of the organs in the sense of Quinke (Fe in the form of deposits), a common occurrence in that disease. The extraordinary quantities of iron in the liver and other organs also do not happen in every case of diabetes. In many cases Fe is met with as an oxide of iron albuminate, but, though in intimate organic union, it cannot be considered stable. The Fe reaction, which, as has been contended, never succeeds when applied to the brain of a diabetic patient, does sometimes result. The normal quantity of iron in the blood of such individuals may also be greatly increased, as Zaleski has proved, contrary to the assertions of other observers.

Tympanites in Hysterical Women.

Professor Talma, of Utrecht, writing on tympanites in hysterical women, relates some interesting facts concerning three of his patients. He believes the cause of this condition to be spasmodic contraction of the diaphragm. The first case mentioned is that of a servant, aged twenty-three, who presented, with exception of paralysis, all the symptoms common to hysterical girls. She sought advice for an eruption on the breast, and whilst under Prof. Talma's treatment, mentioned that she had suffered some months previously from enlargement of the abdomen. The abdomen was even then greatly enlarged, and the girl suffered terribly from hiccough, which increased in violence when any of the students approached her. During sleep the size of the abdomen decreased considerably, and when the patient was put under chloroform it resumed its normal proportions. A tube was passed into the stomach, but no abnormal amount of gas was discovered, nor was any undue quantity found in the intestines. As the effect of the chloroform passed off, the abdomen again increased in size, and Professor Talma noticed that the patient took four or five inspirations without any corresponding expirations. During respiration the abdomen was immovable, and the breathing entirely thoracic; the lower border of the lungs was depressed to the tenth rib. Prof.

Talma was convinced that the enlargement of the abdomen was the result of spasmodic contraction of the diaphragm. The two other cases were those respectively of a servant, aged thirty-five, and a girl, aged fifteen, who had not menstruated. The cases were somewhat similar, and Prof. Talma came to the same conclusion as in the first case as to the cause of the tympanites.

Acromegalia.

In the *Revue Médicale* for April, Dr. Marie gave an account of some singular characteristics he had met with in two cases of acromegalia, taking the form of a non-congenital hypertrophy of the hands, feet, and head. The skeleton of the hands and feet was like a giant's; the soft parts had developed with the bones, consequently there was no apparent deformity. A singular contrast was observed in the forearms, the arms and legs retaining their ordinary size. The head was only large in some parts, although the skull was affected. Hypertrophy had especially developed in the bones of the face, the general aspect of which was that of an elongated ellipse. Minor characteristic deformities were noticeable. The vertebral column was bent forward; some of the bones had increased in size (clavicle, ribs, patella, and ilium); the long bones remained normal. The fibro-cartilages of the ear and larynx showed a tendency to become hypertrophied; the joints were only slightly altered in shape. The muscles were lessened in volume. There were slight blindness and deafness; sudden unexplained pains occurred, difficult to remove. There were a marked tendency to varicose veins and hemorrhoids, and intense thirst. More than the normal quantity of urine was passed. The skin remained intact, but the patient presented cachexia in a mild degree. Acromegalia attacks both men and women between the ages of 15 and 35; its etiology is obscure; excepting the absence of menses, there are no definite symptoms. Dr. Marie believes that acromegalia is a bony malformation analogous to progressive primitive myopathy.

Tubercle Bacilli and Heredity.

Dr. Curt Jani has examined the healthy sexual organs of nine phthisical patients for tubercle bacilli. No bacilli were found in any of these cases in the semen from the vesiculæ seminales, but, on the other hand, in five cases out of eight a small number were found in the testicle and in four out of six in the prostate. There was no pathological

alteration in the tissues of the testes. Besides these cases, Dr. Jani found in one case of acute miliary tuberculosis numberless tubercle bacilli in the tissue of the prostate. He, further, examined two women who died of pulmonary phthisis, the ovaries both times presenting negative results. In one case of chronic pulmonary phthisis, with extensive intestinal tuberculosis, he examined the tubes and found tubercle bacilli. Dr. Jani is of opinion that the tuberculous poison may pass to the fœtus in two ways—through the semen of the male, and through the migration of the bacilli into the womb from the abdominal cavity. Infection of the ovum after impregnation by the placental circulation he thinks must be unusual, because the examination of the body of a woman five months pregnant, who died from acute miliary tuberculosis, in whom the general infection took place through the growth of a caseous mass in a pulmonary vein, showed that there were no tubercle bacilli either in the placental attachment or in the lungs, liver, kidneys, or the epiphyseal lines of the different bones of the fœtus. Dr. Jani, however, considers that it is by no means certain that in chronic miliary tuberculosis deposits may not form in the neighborhood of the placenta, and thus infect the fetal organism.

Scabies.

The importance of recognizing this disease is certainly very great, for it is one of the few diseases that we can cure, while at the same time it is a disease that not only will not get well spontaneously, but while it lasts is constantly a centre for the spread of the affection. In the *Boston M. and S. Jour.* (September 23), Dr. F. B. Greenough says that scabies ought to be recognized (although his experience would show that it by no means always is) by the fact of lesions being found between the fingers, on the ball of the hand, and wrists, if not characteristic burrows, at least small vesicles; by the presence of characteristic lesions on the penis in the male subject; by the existence of secondary manifestations on the forearms, buttocks, abdomen, thighs and legs, more or less developed, as the case is of longer or shorter standing; by a decided increase of discomfort in the way of itching during the night, and by the fact that others who are thrown into intimate relations with the patient are similarly affected.

The treatment that he has used is the old sulphur ointment that Hardy introduced

years ago at the St. Louis—one part of carbonate of potash, two of sulphur, and three of vehicle, for which he has taken petroleum ointment instead of lard. The objection to the use of sulphur is, of course, its irritating action on the eczematous and pustular secondary eruptions. Strict cleanliness must, of course, be enjoined.

Traumatic Pleurisy.

Dr. Seved Ribbing reports, in the Swedish *Eira*, amongst a number of instructive cases, the following one of traumatic pleurisy. A man, who had received a blow on the right side of the thorax in a drunken quarrel, was admitted into the Cimbrishamn's Hospital with the ordinary signs of pleurisy with effusion. The cavity was consequently aspirated, the puncture being made in the eighth intercostal space just below the angle of the scapula. The signs of fluid returning, it was decided to open up the cavity. This was done by an incision in the same situation as that in which the aspiration had been performed, and a quantity of thick fibrinopurulent matter evacuated, a large French œsophageal sound being used for drainage. Two days after the operation it was noticed that the integuments and superficial muscular layer around the shoulder-joint flapped like a curtain at each inspiration. As this pointed to the existence of an abscess cavity communicating with the chest, a sinus was searched for and discovered running upwards from near where the opening into the thoracic cavity had been made. This sinus was laid open, and, together with the chest, carefully drained and washed out with carbolized water. The quantity of fluid which came away diminished daily; the temperature, which had been high, sank; and in three months' time the man was discharged cured.

Blindness and Fecundity.

It has been asserted by Magnus, Fuchs, and others, that children, one or both of whose parents may be blind, are very liable to be themselves blind. Magnus investigated fourteen instances of married couples in whom one or both were born blind, or became blind at an early age, and found that, out of thirty-four children begotten of these marriages, eight, or 23.5 per cent., were either blind or weak-sighted. Mr. Simeon Snell reports, in the *British Medical Journal* of August 7, 1886, thirteen instances of marriages, one or both the contracting parties being blind, in which none of the children had any trouble with the sight nor any

trouble with the eyes. He noticed one curious fact, however, and that was the small proportion of births. There were ten men with sighted wives, and excluding one whose wife had ceased to bear children before his blindness came on, there were left nine, with twenty-six children between them, or less than three per family. Adding to this number three blind couples with two children, there was a total of twelve with twenty-eight children, or two and one-third per family. It would almost seem, therefore, that such marriages are less than usually fruitful. Farr placed the number of children per wife in England as 5.2.

Disease of the Nose Causing Aphonia and Dyspnoea.

Dr. Predborski mentions in the Polish journal *Gazeta Lekarska* a case of aphonia and spasmodic dyspnoea, where the cause was found to be an affection of the nose. A young Jewess, subject from childhood to attacks of epistaxis, received a severe nervous shock, being, in fact, the subject of an attempted violation. After this she completely lost the power of speech, and began to suffer from attacks of spasmodic dyspnoea; her catamenia also ceased. One of the attacks was so alarming that it was thought that tracheotomy would have to be performed, and preparations were made for the operation, but, on chloroform being given, her condition improved so much that she not only breathed more easily, but began to scream, so that all thought of operative procedures was abandoned. In a few weeks' time the girl seemed much better, but subsequently the symptoms reappeared. The nose, on examination, showed that the lower and middle turbinated bones on the left side were red and tumefied. When they were touched pain was produced, accompanied by sneezing and discharge of mucus. The application of chromic acid quickly and completely restored the patient to her usual state of health.

The Peroneal Type of Progressive Muscular Atrophy.

The thesis prepared by Dr. Howard Tooth for the degree of M. D. in the University of Cambridge contains valuable information and an excellent bibliography. The author of the thesis contends that there is a form of progressive muscular atrophy which commences in the lower extremities, most often in the peroneal muscles, but sometimes in the tibialis anticus, extensor longus digitorum,

or gastrocnemius; that the hand and forearm muscles are attacked at an early period; that the disease is one of childhood; that heredity is a marked feature; that the disease shows a slight preference for the male sex; that fibrillar or fascicular tremors are frequently though not always present; that degenerative electrical reactions are often an early phenomenon; and, lastly, that from a record of necropsies, as well as from the clinical symptoms, it may be inferred that the disease is one affecting the peripheral nerves.

Mechanical Removal of Croupous Exudation After Tracheotomy.

After tracheotomy for croup, when it is found impossible to clear the trachea from membrane by forced expirations, suction, etc., Dr. Pievigzèk, writing in the *Przegląd Lekarski*, advises the use of Schrötter's forceps, which, he says, should be so introduced through the wound that the blades may open antero-posteriorly, and not laterally, for fear of taking up the angle at the bifurcation of the bronchi. Sometimes it is possible completely to clear the trachea by one or two introductions of the forceps. In cases where the obstruction is in one of the bronchi, the patient should be laid on the corresponding side and the forceps inclined accordingly. Information may also be obtained as to the situation of the obstruction by the aid of a mirror introduced into the wound, the patient's head being at the same time thrown well back. The instrument which the author finds most suitable for this purpose is Zangfal's nasal speculum. He remarks that children bear the operation without any special trouble.

Cocainomania.

Erlenmeyer, in the *Deutsche Medicinal Zeitung* (1886, No. 46), has studied the symptoms in a number of individuals who have used cocaine to excess, by subcutaneous injection or otherwise. The characteristic symptoms denote vaso-motor paralysis, the pulse is accelerated, the sweats profuse, and dyspnoea and syncope ensue. Failure of general nutrition is very notable, the eyes become sunken, and the skin of cadaveric hue. At a more advanced stage psychic troubles supervene, sometimes requiring personal restraint. Most of the persons so affected had previously been addicted to the abuse of morphia, and cocaine had been resorted to as the minor evil. It would therefore be unjust to lay too large a share of the

troubles noted at the door of cocaine; still, enough evidence is at hand to prove that it may be productive of evil consequences, and should only be used as a powerful medication with circumspection.

Ichthyol in Rheumatism.

Dr. Dubelir (*Russkaya Meditsina*, August 10, 1886,) reports eight cases of rheumatism treated by ichthyol at the Moscow Military Hospital. Six of the cases were acute, and two chronic. The preparation was used both internally and externally. The affected parts were first washed off with soap and water, dried, and then smeared with the ichthyo-sulphate of ammonium, and covered with cotton or flannel. After long use, or when the skin was insufficiently or not regularly washed, pustules were caused by the application. Internally the author gave fifteen to twenty-five drops of the ichthyo-sulphate of ammonium in a wineglass of water, or else administered the remedy in the form of pills of one and a half grain each, from six to twelve pills a day. In every case the pains were quieted, but the swelling of the parts did not disappear. The writer advises, therefore, that ichthyol be given in rheumatism only for its anodyne effects.

Henocque's Hæmatoscopic Method.

M. Hénocque exhibited to the Medical Congress at Nancy in August his apparatus for investigating the blood by *hæmatoscopy*. The process consists in first determining the amount of oxyhæmoglobin in the blood by the hæmatoscope, and then estimating the time required for its reduction by observing its passage across the thumb-nail through a direct vision spectroscope. The activity of reduction varies independently of the quantity of oxyhæmoglobin, being generally increased in persons of sanguine habit and in patients with arthritic and rheumatic diseases, and diminished in those with anæmia, chlorosis, epilepsy, temporary bilious disturbances, menstrual troubles, and in certain stages of phthisis.

A Recovery from Hydrophobia.

In the *N. Y. Med. Jour.* we read that in October of 1884 a physician now living in a neighboring city was bitten by a rabid dog. The wound, which was on the right thigh, suppurated; there was much constitutional disturbance, and, according to his own statement, a distinct and severe hydrophobic convulsion. The marks of the animal's teeth are still plainly visible; the affected thigh

and its fellow are covered with reddish-brown maculæ varying in size from that of a large pin-head to that of a silver three-cent piece, and both thighs are exquisitely sensitive.

NEWS AND MISCELLANY.

Meeting of the Committees of Conference of the Various Special Associations requested to Participate in Conjoint Session.

In response to the notice issued by the Secretary of the Committee of Conference of the American Surgical Association, the Committees of Conference met at the Army Medical Museum, Washington, D. C., at 12 o'clock noon, on Friday, September 24, 1886.

The meeting was organized by the election of Dr. S. C. Busey, of Washington, Chairman, and Dr. J. Ewing Mears, of Philadelphia, Secretary.

The Secretary reported that he had received notification of the appointment of the following committees:

1. *American Ophthalmological Association*.—O. F. Wadsworth, M. D., Boston; C. T. Bull, M. D., New York; George C. Harlan, M. D., Philadelphia; Samuel Theobald, M. D., Baltimore; R. E. Freyer, M. D., Kansas City, Mo.
2. *American Otological Association*.—C. R. Agnew, M. D., New York; H. Knapp, M. D., New York; John Green, M. D., St. Louis; W. H. Carmalt, M. D., New Haven, Conn.; George Strawbridge, M. D., Philadelphia.
3. *American Gynecological Society*.—S. C. Busey, M. D., Washington; Fordyce Barker, M. D., New York; J. R. Chadwick, M. D., Boston; J. Taber Johnston, M. D., Washington; Thomas A. Emmet, M. D., New York.
4. *American Laryngological Association*.—J. Solis Cohen, M. D., Philadelphia; F. I. Knight, M. D., Boston; G. W. Lefferts, M. D., New York; F. H. Bosworth, M. D., New York; E. L. Shurley, M. D., Detroit.
5. *American Dermatological Association*.—H. G. Piffard, M. D., New York; F. B. Greenough, M. D., Boston; R. B. Morrison, M. D., Baltimore; L. N. Denslow, M. D., St. Paul, Minn.; G. H. Tilden, M. D., Boston.
6. *American Medical Association*.—C. H. Mastin, M. D., Mobile; C. T. Parkes, M. D., Chicago; N. Senn, M. D., Milwaukee; J. Ford Thompson, M. D., Washington; J. Ewing Mears, M. D., Philadelphia.

7. *American Neurological Association*.—L. C. Gray, M. D., Brooklyn; J. Van Bibber, M. D., Baltimore; E. C. Seguin, M. D., New York; Wharton Sinkler, M. D., Philadelphia; Philip Zenner, M. D., Cincinnati.

8. *American Climatological Association*.—A. L. Loomis, M. D., New York; F. Donaldson, M. D., Baltimore; F. C. Shattuck, M. D. Boston; E. T. Bruen, M. D., Philadelphia; W. W. Johnston, M. D., Washington.

9. *Association of American Physicians and Pathologists*.—Wm. Pepper, M. D., Philadelphia; Francis Delafield, M. D., New York; R. T. Edes, M. D., Boston; J. Palmer Howard, M. D., Montreal; J. T. Whittaker, M. D., Cincinnati.

The roll was called and the following members of the committees answered to their names:

1. *Ophthalmological Association*.—O. F. Wadsworth, M. D., Samuel Theobald, M. D.

2. *Otological Association*.—C. R. Agnew, M. D., W. H. Carmalt, M. D.

3. *Gynecological Society*.—S. C. Busey, M. D., J. R. Chadwick, M. D., J. Taber Johnston, M. D.

4. *Laryngological Association*.—F. I. Knight, M. D., E. Shurly, M. D.

5. *Dermatological Association*.—H. G. Piffard, M. D., G. H. Tilden, M. D.

6. *Surgical Association*.—C. H. Mastin, M. D., J. Ford Thompson, M. D., J. Ewing Mears, M. D.

7. *Neurological Association*.—L. C. Gray, M. D., J. Van Bibber, M. D.

8. *Climatological Association*.—F. Donaldson, M. D., W. W. Johnston, M. D.

9. *Association of American Physicians*.—Wm. Pepper, M. D.

Dr. Wm. Thomson, of Philadelphia, was present as a member of the committee of the Otological Association, in place of Dr. Geo. Strawbridge, who had resigned from the committee; and Dr. W. Hendrie Lloyd, of Philadelphia, was present as a member of the committee of the Neurological Association, in place of Dr. Wharton Sinkler, who had resigned.

On motion, it was resolved that the Associations represented should vote by title, taken in chronological order, and as a unit.

Dr. Wm. Pepper offered the following resolutions, which, after careful consideration and discussion by those present, were adopted separately, and then as a whole:

Resolved, 1. That it is desirable that the following societies—the American Surgical Association, American Ophthalmological Association, American Otological Association, American Neurological Association, Ameri-

can Gynecological Association, American Dermatological Association, American Climatological Association, Association of American Physicians and Pathologists—shall arrange for a conjoint meeting in the city of Washington, in the month of September, 1888, and subsequently at intervals of three years, at the same time and place.

2. That this arrangement shall not interfere in any way with the autonomy of each special society; and that each society shall retain the right to withdraw at any time from this conjoint scheme.

3. That the special feature of the meeting shall be the conjoint assemblage of the special societies on two evenings during the session; on one of which there shall be an address delivered by the President of the conjoint meeting, and on the other there shall be communications by a referee and a co-referee on some subject of general professional interest.

4. That each special society approving this report is invited to appoint one representative (with an alternate), and that the representative so appointed shall constitute an executive committee to serve for one year, with power to elect such officers for the first conjoint meeting as may be deemed necessary; to prepare a programme for said meeting; to make all other necessary arrangements; and to prepare and submit a plan of organization for future meetings.

5. That all expenses connected with the conjoint sessions shall be apportioned equally by the executive committee among the special societies participating.

Owing to the views entertained by the committees of the Ophthalmological and Dermatological Associations with regard to intervals of times of the meetings, they abstained from voting upon the first resolution.

The Secretary was instructed to send to the medical journals of the country a report of the proceedings of the meeting, a printed copy of the same to each member of each Association participating, and a certified copy to the Secretary of each Association.

American Academy of Medicine.

The tenth annual meeting will be held in the chapel of the First Presbyterian church, Wood street, near Fifth avenue, Pittsburgh, Pa., Tuesday and Wednesday, October 12th and 13th, 1886.

TUESDAY, OCT. 12, AT 10 O'CLOCK A. M.

Opening of session, with prayer; reading of minutes of last annual meeting; report of council; election of fellows; amendments to

the constitution and by-laws; appointment of Committee on Nominations; new business.

Report on the Present Working of Laws Regulating Medical Practice, by Richard J. Dunglison, A. M., M. D., of Philadelphia, Pa., and Henry O. Marcy, A. M., M. D., of Boston, Mass.

Reading of papers:

"The Best Equipment for Medical Study." By Frederic H. Gerrish, A. M., M. D., of Portland, Maine.

"The Two Standards, Literary and Medical." By R. Lowry Sibbet, A. M., M. D., of Carlisle, Pa.

AT 3 O'CLOCK, P. M.

New business. Report of Standing Committee on the Requirements for Preliminary Education in the various Medical Colleges of the United States and Canada. Report of Special Committee on the best Preliminary Education for Medical Students.

Reading of Papers:

"The Status of Medical Education in the United States." By John D. Kelly, A. M., M. D., of Lowville, N. Y.

"The Advantages of a Classical Education to the Medical Student and the Physician." By L. P. Bush, A. M., M. D., of Wilmington, Del.

"A Christian Education the Best Preparation for the Practice of Medicine." By Andrew C. Kemper, A. M., M. D., of Cincinnati, Ohio.

"Prolonged Gestation." By J. Cheston Morris, A. M., M. D., of Philadelphia, Pa.

AT 8 O'CLOCK, P. M.

Address by the President, R. S. Sutton, A. M., M. D., of Pittsburgh, Pa.

AFTER THE PRESIDENT'S ADDRESS.

Annual collation of the Academy at the Hotel Duquesne, Smithfield street, opposite City Hall.

Tickets for the collation (fixed, by resolution of the Academy, at two dollars each) may be obtained by remitting the amount to Dr. S. N. Benham, 156 Third avenue, Pittsburgh, Pa.

WEDNESDAY, OCT. 13, AT 10 O'CLOCK, A. M.

New business. Treasurer's report. Report of Committee on Nominations.

Reading of papers:

"The Duties of Physicians to each Other." By Traill Green, A. M., M. D., of Easton, Pennsylvania.

"The Medical Service of the United States Pension Bureau." By Phineas S. Conner, A. M., M. D., of Cincinnati, Ohio.

"The Treatment and Management of Tu-

bercular Spondylitis." By Virgil P. Gibney, A. M., M. D., of New York, N. Y.

"Is Modern Wound Treatment Scientific?" By Henry O. Marcy, A. M., M. D., of Boston, Mass.

"Physical Culture in Amherst College." By Nathan Allen, A. M., M. D., of Lowell, Mass.

"What Should Physicians Advise as to the Education of Young Women?" By George E. Stubbs, A. M., M. D., of Philadelphia, Pa.

"The Relation of Specialism to General Medicine: Is it a Result of a Higher Education?" By William S. Little, A. M., M. D., of Philadelphia, Pa.

New business. Induction of President-elect. Appointments for ensuing year (additional members of council; Standing Committee on Requirements for Preliminary Education. Unfinished business. Adjournment.

AT 1:30 O'CLOCK, P. M.

The Fellows are invited by Dr. R. S. Sutton, President of the Academy, to take lunch at his residence, 419 Penn avenue.

College of Physicians of Philadelphia.

At the meeting of the College held on Wednesday evening, October 6, Dr. Henry Hartshorne read a memoir of the late Dr. Edward Hartshorne; Dr. Ruschenberger, "An Account of the Institution of the College of Physicians of Philadelphia;" and Dr. Thomas B. Reed described a plan for a Children's Ward at the Presbyterian Hospital.

NEW BOOKS ADDED TO THE LIBRARY DURING SEPTEMBER, 1886.

General Library.

Field, B. Rush.—Medical Thoughts of Shakespeare. 8vo. Easton, 1885.

Congrès Français de Chirurgie.—1er Session, Paris, 1885. 8vo. Paris, 1886.

Index Catalogue Library Surgeon-General's Office.—Vol. 7. Ins.—Leg.

Lewis Library.

Starr, Louis.—Diseases of the Digestive Organs in Infancy and Childhood. 8vo. Philadelphia, 1886.

Lemoine, G.—De l'Antisepsie Médicale. 8vo. Paris, 1886.

Simon, P.—Des Fractures Spontanées. 8vo. Paris, 1886.

Chuffart.—Des Affections Rhumatismales du Tissu Cellulaire sous-cutané. 8vo. Paris, 1886.

Dejerine, J.—L'hérédité dans les Maladies du Systeme Nerveux. 8vo. Paris, 1886.

Van Merris, C.—*La Scrofule et les Bains de mer*. 8vo. Paris, 1886.

Baker, H. F.—*Practical Notes on the Treatment of Deformities*. 8vo. London, 1886.

Lays of the Colleges. 8vo. Edinburgh, 1886.

Sharkey, S. J.—*Spasms in Chronic Nerve Disease*. 8vo. London, 1886.

Brunton, T. Lauder.—*On Disorders of Digestion*. 8vo. London, 1886.

Farr, William.—*Vital Statistics*. 8vo. London, 1885.

Radcliffe, C. B.—*A New Chapter in the Story of Nature*. 8vo. London, 1886.

Sutton, J. B.—*An Introduction to General Pathology*. 8vo. London, 1886.

Masson.—*De l'Origine du Sang en Médecine Légale*. 8vo. Paris, 1885.

Berjon, A.—*Le Grande Hystérie chez l'Homme*. 8vo. Paris, 1886.

Skwortzkoff, Mlle. Nadine.—*De la Cécité et de la Surdité des mots dans l'Aphasie*. 8vo. Paris, 1881.

Moussous, A.—*De la mort chez les Phtisiques*. 8vo. Paris, 1886.

Broca, A.—*Étude Clinique sur quelques Lésions Cutanées des Membres Variqueux*. 8vo. Paris, 1886.

Lachèse, Lanoaille de.—*Trassis Troubles de l'ame et du corps chez l'Homme*. 8vo. Paris, 1886.

Irregular Medical Schools.

The *Jour. Am. Med. Ass.*, October 2, says that the Iowa State Board of Health will not recognize diplomas from the following colleges: American Eclectic College, Cincinnati; American Health College, Cincinnati; American University of Pennsylvania (Buchanan), Philadelphia; Beach Medical Institute, Indianapolis; Bellevue Medical College of Massachusetts; College of Physicians and Surgeons, Buffalo, N. Y.; College of Physicians and Surgeons, Milwaukee; Eclectic Medical College of Philadelphia; Edinburgh University, Chicago and St. Louis; Excelsior Medical College, Boston; Hygeo-Therapeutic College, Bergen Heights, N. J.; Hygeo-Therapeutic College, New York City; Joplin Medical College, Joplin, Missouri; Livingston University, Haddonfield, N. J.; Medical Department of the American University of Boston, Boston; New England University of Arts and Sciences, Boston; New England University of Arts and Sciences, Manchester, N. H.; Penn Medical University, Philadelphia; Philadelphia University of Medicine and Surgery,

Philadelphia; Physio-Eclectic Medical College and Physio-Medical College, Cincinnati; St. Louis Eclectic Medical College, St. Louis; St. Louis Homeopathic Medical College, St. Louis; Curtis Physio-Medical Institute, Marion, Indiana; American Anthropological University, of St. Louis; Medical Department of Drake University, Des Moines, Iowa; and King Eclectic Medical College, Des Moines, Iowa.

Scottish Mediæval Medicine.

The ninth King of Scots, if we may believe the early chroniclers, rendered his reign memorable by the high honor in which he held physicians. It was in Ireland, where he spent years of exile with his father, says Buchanan, that he became familiar with medicine and its practitioners. When settled on the throne of Scotland he so inspired the courtiers with his medical tastes that the healing art, particularly surgery, became quite a patrician accomplishment, and for centuries afterwards "nemo esset in Scotia illustriore loco natus, qui vulnerum curationem non teneret." Even down to the sixteenth century surgery, especially military surgery, was a *métier* in which the Scottish aristocracy were proficient. The gallant King James IV. pursued, according to Buchanan, the traditional practice of his race and ancestry with much zeal. "Unum e vetusta gentis consuetudine hausit avide, ut vulnera scientissime tractaret; cujus rei peritiam toti Scotorum Nobilitati, ut hominibus in armis assidue viventibus, fuerat priscis temporibus communis." (One thing he imbibed eagerly from the ancient custom of the Scots—to wit, the thoroughly scientific treatment of wounds: a department in which, from remote times, the whole Scottish nobility, as men living constantly under arms, had shared a common skill.)

Cholera in Hungary.

The number of those attacked by cholera at Buda-Pesth is again on the increase, say advices from Vienna of the 19th ulto., whereas the fatal cases are not so numerous. From the 12th to the 18th of September, 61 cases of sickness and 19 deaths occurred. The Cholera Commission has discovered practices dangerous to health. In each of two houses belonging to a nobleman there were discovered from 150 to 200 persons lying together on the bare ground in the courtyard. In a cellar, 40 persons of both sexes were found sleeping together on the

ground. A number of such dwellings have been visited. In Vienna and Lower Austria, strenuous preventive measures are being adopted, although there has not as yet been reported a single case of cholera. The Servian Government has decreed a seven days' quarantine for travelers and goods coming from Hungary. At Odessa, a fourteen days' quarantine has been decreed for goods arriving from the Danubian ports. The five days' quarantine imposed at Constantinople consists, it is stated, in remaining five days on board of a steamer at the entrance of the Bosphorus. Fumigation is not regularly applied. There is, it is said, no chance of an early suppression of this quarantine.

An Undesirable Experiment.

A recent incident in the Michigan College of Medicine has been a source of much anxiety to more than one of the parties concerned. One of the professors of clinical medicine was giving his final lecture to the class on the subject of venesection. No patient being at hand upon whom the operation could be performed, the lecturer asked for a volunteer. One of the students responded, and was bled. The demonstration was successful; but subsequently inflammation of the wound supervened, followed by abscess, erysipelas, etc., and caused the gravest anxiety to the student, his parents and fellows, and to the operator himself. Fortunately, the patient is convalescent. The incident is one which may well be borne in mind by would-be observers. We are already familiar with experiments on the human subject, which, whatever their value as arguments, have led to more or less serious consequences. The experimenters were in many cases students, and were, therefore, probably undeterred by consideration for their wives and families; but certainly some caution is desirable, since a fatal result would, in all probability, result in a verdict of manslaughter against the victim's accomplices.

Prohibition "Beverages."

David W. Judd writes from Iowa to the *American Agriculturist*:

However much the citizens of Iowa may disagree as to the prohibition laws, provided for by both the State Constitution and the votes of the Legislature, strangers cannot be otherwise than impressed with the remarkable effects of these prohibition enactments; and the innovation often borders on the humorous. For example, instead of seeing, as in the saloons surrounding the railroad

depots in other States, such "bulletins" as "Old Crow," "Whisky Punches," "Hot Scotchies," "Kentucky Blue Grass," etc., etc., one is informed by the placards in saloons surrounding the depots at Des Moines and other points in Iowa, that "Hot Coffee," "Hot Tea," and "Pure Lemonade," etc., etc., are "served up here." Of course this order of things provokes no little opposition. But wait, say the earnest advocates of temperance, until you read the reports, after two years, from our Iowa prisons and jails, until you see how much our taxes are reduced by the absence of murder trials, and the expenses attending all the other crimes and excesses resulting from "free rum."

How to Detect a Morphine-Taker.

Professor Bull, of Paris, states that there are two ways by which the morphine habitué can be detected, and these are to be found in the skin and in the urine. The skin will be found to be covered with little dark spots situated in the centre of little indurations about the size of a large shot. It is needless to add that the indurations are the result of the little wound of the needle, but as these lesions are generally found on the inside of the thighs, the patient refuses to let them be seen, and in that case examination of the urine will prove of great service. A few drops of tincture of iron are put into the suspected liquid, and if morphia be present a blue tinge will be produced.

Official List of Changes

OF STATIONS AND DUTIES OF MEDICAL OFFICERS OF THE
UNITED STATES MARINE HOSPITAL SERVICE,
FOR THE WEEK ENDED SEPTEMBER
25, 1886.

Bailhache, P. H., surgeon. Granted leave of absence for thirty days, September 25, 1886.

Vansant, John, surgeon. Granted leave of absence for thirty days, September 24, 1886.

Bratton, W. D., assistant surgeon. Relieved from duty on Revenue Steamer "Corwin;" ordered to duty at Marine Hospital, San Francisco, Cal., September 20, 1886.

Therapeutic Notes.

Platt's Chlorides.—As the prevention of disease becomes of increased importance with the progress of medical science, so will the use of disinfectants as sanitary agents. Of the many which are now obtainable, we may specify as of marked excellence the

combination of chlorides sold by Mr. Platt and described in our advertising columns. They are particularly useful in the sick room, and there is a special call for their exhibition during the winter season, when houses are closed from the external air.

A Brutal Physician.

A French journal states that a physician was called in the night to see a woman in childbirth. The labor was complicated, and an operation was necessary, for the performance of which the physician demanded 250 francs in advance. The husband was a laboring man, and had but 100 francs, which he offered, with promises to pay the balance. The doctor refused in spite of the man's entreaties. Before another physician could be obtained, the woman died in great agony, two lives having thus probably been sacrificed for the paltry sum of thirty dollars.

Veterinary Medicine.

New York is the only State as yet which has undertaken to regulate the practice of veterinary medicine and surgery. A law has been passed requiring the registration of all practitioners with the evidence of proper qualification afforded by a diploma from some legally incorporated college or a certificate from an incorporated veterinary society. The first class in veterinary medicine, consisting of five members, graduated from Harvard University, June 30.

Another Hermaphrodite.

Among the replies to an advertisement of a musical committee for "a candidate as organist, music-teacher, etc.," was the following one: "Gentlemen—I noticed your advertisement for an organist and music-teacher, either lady or gentleman. Having been both for several years, I offer you my services."

Association of the Surgeons of the Pennsylvania Company.

The eighth semi-annual meeting of this Association will be held at the Seventh Avenue Hotel, Pittsburgh, Pa., Tuesday October 19, 1886, commencing at 9 a. m., Eastern time. A number of papers on appropriate subjects are promised.

Loomis Laboratory.

This is to be the name of a new building for the medical department of the Univer-

sity of New York, for the construction and maintenance of which \$100,000 has recently been contributed by a gentleman who, for the present, withholds his name from publication.

Personal.

—Dr. S. D. Risley has removed to No. 1722 Walnut street.

Items.

—The seventh volume of the "Index Catalogue of the Library of the Surgeon-General's Office" has just been issued. It brings the index down to "Leghorn."

—Dr. Pekelharing, Professor of Medicine in the University of Utrecht, has been instructed by the government at the Hague to proceed to Acheen to make special inquiry into the nature of the malady known as "beri-beri."

—A gratuity of £10,000 has been granted from the Bavarian civil list to the widow of Professor von Gudden, of Munich, who perished with the late King of Bavaria in the lake at Castle Berg. He left a family of eleven children.

—The number of students in the Imperial University of Tokio is said, by the *Medical Record*, to be nearly one thousand, a large proportion of whom are students of medicine. Five of the professors in the medical faculty are Germans.

—The State Board of Health suffers a severe loss in the resignation of Dr. E. M. Moore, of Rochester, which has just been announced. Dr. Moore was one of its original members, and has always been one of the valuable and active workers in its service.

—A novel way of reassuring a patient was lately resorted to by a dentist in Mexico. A patient was to have a tooth extracted, but the preparations so frightened him that he declined to submit to the operation. To allay his fears, the dentist made his office boy open his mouth, and in a twinkling took out one of his teeth. We are not surprised to learn that the little fellow threw up his situation at once.

—The Paris Municipal Council have decided to open a hygienic museum, in which the microscopic effects of allowing water to stagnate, the skin to remain dirty, and bad air on the blood, will be shown, as well as other causes of disease. Lectures on the laws of health will be delivered in connection with the exhibition.